Filing at a Glance

Company:	UnitedHealthcare Insurance Company
Product Name:	COL-17-DC (PY20) POL
State:	District of Columbia
TOI:	H15G Group Health - Hospital/Surgical/Medical Expense
Sub-TOI:	H15G.002 Large Group Only
Filing Type:	Form
Date Submitted:	02/10/2020
SERFF Tr Num:	UHLC-132234351
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	COL-17-DC(PY20)POL
Implementation Date Requested:	On Approval
Author(s):	Mark Wenshau
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *District of Columbia* **Filing Company:** *UnitedHealthcare Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.002 Large Group Only*
Product Name: *COL-17-DC (PY20) POL*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Blanket
Filing Status Changed: 02/12/2020
State Status Changed:
Created By: Mark Wenshau
Corresponding Filing Tracking Number: UHLC-132234352

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: State-specific forms have been filed in our domiciliary state of Connecticut.
Market Type: Group
Group Market Size: Large
Overall Rate Impact:
Deemer Date:
Submitted By: Mark Wenshau

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Enclosed for your consideration and approval is our original submission of the above referenced blanket student injury and sickness forms. The forms are revised versions of previously approved forms as described below.
Revisions have been made to the Policy, Certificate of Coverage, [UnitedHealthcare Network Pharmacy (UHCP)] Prescription Drug Benefits Endorsement, and Schedule(s) of Benefits to create (PY20) versions. The revisions are being made due to regulatory and administrative changes as described below and will be used beginning with the 2020-2021 academic policy year.
Policy Form COL-17-DC (PY20) POL
This form will replace form COL-17-DC POL approved on March 8, 2017, under SERFF Submission # UHLC-130812682. The changes are as follows:
1.Modified the face page to reference Policy attachments by name instead of form number.
2.Made administrative updates such as date updates and bracketing corrections to aid with issue of the form.
Certificate of Coverage Form COL-17-DC (PY20) CERT
This form will replace form COL-17-DC (PY19) CERT approved on June 26, 2019, under SERFF Submission # UHLC-131911323. The changes are as follows:
1.Modified the Mandated Benefit[s] for Mental Illness and Substance Use Disorders to clarify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
2.Revised the Reproductive/Infertility exclusion for clarity on page 25.
3.Revised the Ombudsman’s Office address in our Notice of Appeal Rights section on page 30.
4.Made administrative updates to aid with issue of the form.

[UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Endorsement Form COL-17-DC (PY20) END RX
This form will replace form COL-17 END RX approved on March 8, 2017, under SERFF Submission # UHLC-130812682. The changes are as follows:
1.Added refill dispensing requirements for certain controlled medications.
2.Made administrative updates to remove “through the Internet” and “[the telephone number on the Insured’s ID card].”
3.Added a description of the Prescription Drug Deductible option.
4.Changed the title of the definition of Preventive Care Medications to PPACA Zero Cost Share Preventive Care Medications. Also revised the text of this definition.

5.Added variables to the Notification requirements sections to allow for either reference to Notification or Prior Authorization.
6.Added the following exclusion as the final exclusion in the endorsement. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
7.Made additional language updates to aid with administration and issue of the form.

Schedule of Benefits Forms COL-17-DC (PY20) SOB PPO and COL-17-DC (PY20) SOB
These forms will replace forms COL-17-DC SOB PPO and COL-17-DC SOB approved on March 8, 2017, under SERFF Submission # UHLC-130812682. The changes are as follows:
1.Removed the Copays variable paragraph from the top of the Schedule.
2.Added a variable paragraph pertaining to Covered Medical Expenses incurred outside the United States to the top of the Schedule.
3.Added variables for [after Deductible] and [not subject to Deductible] to most line item services.
4.PPO Schedule – added [Not Available] to the Preferred Provider and [In-Network Provider] Prescription Drug benefits for use when the plan does not utilize a pharmacy network for prescription drug benefits.
5.Made additional administrative changes to the prescription drug benefit variables.
6.Modified the Mental Illness Treatment and Substance Use Disorder Treatment benefits to clarify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Redline versions of the revised forms are attached in the supporting documents tab within this new SERFF filing.
We will continue to use the following previously approved forms with the revised forms included in this submission. These forms remain the same as the previously approved versions:

FormSERFF Submission/Approval
COL-17 END PEDDENTUHLC-130812682 / Approved March 8, 2017
COL-17 END PEDVISUHLC-130812682 / Approved March 8, 2017
COL-17-DC (PY18) END RMEUHLC-131411016 / Approved May 23, 2018
COL-17-(PY19) END RMESPNUHLC-131911323 / Approved June 26, 2019
COL-17 –DC AP1UHLC-130812682 / Approved March 8, 2017

Applicable forms are being filed concurrently in our domiciliary state of Connecticut.

Also enclosed is the required readability certification, and filing forms for approval. Please note our corresponding rate filing will be filed under separate SERFF Filing # UHLC-132234352 once finalized by our Actuarial Department. It is understood this form filing will be “Closed” by your Department until the rate filing is approved.

Company and Contact

Filing Contact Information

Mark Wenshau, Compliance Analyst
UnitedHealthcare
StudentResources
2301 W. Plano Parkway
Suite 300
Plano, TX 75075

mwenshau@uhcsr.com
866-808-8305 [Phone] 6859 [Ext]
469-229-5535 [FAX]

State: *District of Columbia* ***Filing Company:*** *UnitedHealthcare Insurance Company*
TOI/Sub-TOI: *H15G Group Health - Hospital/Surgical/Medical Expense/H15G.002 Large Group Only*
Product Name: *COL-17-DC (PY20) POL*
Project Name/Number: */*

Filing Company Information

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number: 79413

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

SERFF Tracking #:	*UHLC-132234351*	***State Tracking #:***		***Company Tracking #:***	*COL-17-DC(PY20)POL*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.002 Large Group Only*		
Product Name:	*COL-17-DC (PY20) POL*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: COL-17-DC (PY20) POL

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Blanket Student Injury and Sickness Policy Form	COL-17-DC (PY20) POL	POL	Initial			COL-17-DC (PY20) POL.pdf
2		Certificate of Coverage	COL-17-DC (PY20) CERT	CER	Initial			COL-17-DC (PY20) CERT.pdf
3		Schedule of Benefits - Usual and Customary	COL-17-DC (PY20) SOB	SCH	Initial			COL-17-DC (PY20) SOB.pdf
4		Schedule of Benefits - PPO	COL-17-DC (PY20) SOB PPO	SCH	Initial			COL-17-DC (PY20) SOB PPO.pdf
5		[UHCP] Prescription Drug Endorsement	COL-17 (PY20) END RX	CERA	Initial			COL-17 (PY20) END RX.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office Address: P. O. Box 809025, Dallas, Texas 75380-9025

Blanket Student Accident and Sickness Policy

POLICYHOLDER	[Any School]	**POLICY NUMBER**	[20-00000-00]
ADDRESS	[123 Any Street] [Any City, District of Columbia]	**Effective Date** **Termination Date**	[8-1-2020] at 12:01 a.m. [7-31-2021] at 11:59 p.m.

PREMIUM FOR EACH INSURED PERSON

See Application Attached

LIST OF FORMS ATTACHED TO AND FORMING A PART OF THIS POLICY
Policyholder Application
Certificate of Coverage
Schedule of Benefits
Pediatric Dental Services Benefits Policy Endorsement
Pediatric Vision Care Services Benefit Policy Endorsement
[[UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Benefits Policy Endorsement]
[Assistance and Evacutaion Benefits Policy Endorsement]

UNITEDHEALTHCARE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this Policy, including the attached forms, to pay the benefits provided by this Policy for loss resulting from a cause covered by this Policy. This Policy is issued in consideration of the application and payment of the premiums as specified in the application. Premiums are payable for each Insured Person.

Non-Renewable One Year Term Insurance – This Policy Will Not Be Renewed

President

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this Policy at any time up to the later of: 1) two years after the termination of this Policy; and 2) the date of final adjustment and settlement of all claims under this Policy.

Eligibility

Each person who belongs to one of the "Classes of Persons to be Insured" as set forth in the Policyholder application is eligible to be insured under this Policy.

1. [[The Named Insured must actively attend classes for at least the first [1-45] days after the date for which coverage is purchased.]
2. [[Home study,] [correspondence,] [and] [online] courses do not fulfill the eligibility requirements[that the Named Insured actively attend classes].]

The Company maintains its right to investigate [eligibility or] student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.]

[The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse[or Domestic Partner who meets the specific requirements set forth in the “Definitions” section of this Policy].
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the "Definitions" section of this Policy.

[Dependent eligibility expires concurrently with that of the Named Insured.]]

Eligible persons may be insured under this Policy subject to all of the following:

1. Payment of premium as set forth on the Policy application.
2. Application to the Company for such coverage.

Effective and Termination Dates

Effective Date: Insurance under this Policy shall become effective on the later of the following dates:

1. The Effective Date of the Policy.
2. The date premium is received by the Administrator.
3. With respect to coverage for the Named Insured, the first day of the period for which premium is paid.

[Dependent coverage will not be effective prior to that of the Named Insured.]

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1. The last day of the period through which the premium is paid.
2. The date the Policy terminates.

[The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

1. The last day of the period through which the premium is paid.
2. The date the Policy terminates.
3. [The date the Named Insured's coverage terminates.]]

General Provisions

BENEFITS: The Named Insured [and any enrolled Dependents] are entitled to benefits for Covered Medical Expenses subject to the terms, conditions, limitations and exclusions set forth in the Certificate of Coverage, Schedule of Benefits, and any Endorsements or amendments attached to this Policy. Each Certificate of Coverage and Schedule of Benefits, including any Endorsements or amendments, describes the Covered Medical Expenses and the terms, conditions, limitations and exclusions related to coverage.

ENTIRE CONTRACT CHANGES: This Policy, including the Certificate of Coverage, Schedule of Benefits, Endorsements, Policyholder Application, and attached papers, if any, shall constitute the entire contract between the parties. No agent has authority to change this Policy or to waive any of its provisions. No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an Endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each Policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the Policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the Policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, [P.O. Box 809026, Dallas, Texas 75380-9026].

INDIVIDUAL CERTIFICATES: A Certificate of Coverage, including a Schedule of Benefits and any attachments, will be available: 1) to the Policyholder for delivery to the Named Insured; or 2) directly to the Named Insured.

The Certificate sets forth: 1) an Insured Person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided; and 2) to whom the insurance benefits are payable.

CONFORMITY WITH STATUTES: Any provisions of this policy which, on the Effective Date of Coverage, are in conflict with the statues of the state of issue on that date are amended to conform to such statutes. The state of issue is shown on the policy face page.

UNITEDHEALTHCARE INSURANCE COMPANY

BLANKET STUDENT ACCIDENT AND SICKNESS [PLAN]

CERTIFICATE OF COVERAGE

[Designed Especially for [the [Insert Category of Student Here] [Students] of]]

[ANY [UNIVERSITY]]
[Any town, DC]
[School Logo / Picture]

[2020-2021]

This Certificate of Coverage is Part of Policy # [XX-XXXX-XX]

This Certificate of Coverage ("Certificate") is part of the contract between UnitedHealthcare Insurance Company (hereinafter referred to as the "Company") and the Policyholder.

Please keep this Certificate as an explanation of the benefits available to the Insured Person under the contract between the Company and the Policyholder. This Certificate is not a contract between the Insured Person and the Company. Amendments or endorsements may be delivered with the Certificate or added thereafter. The Master Policy is on file with the Policyholder and contains all of the provisions, limitations, exclusions, and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

Table of Contents

Introduction

Welcome to the [UnitedHealthcare StudentResources] Student Injury and Sickness Insurance Plan. This plan is underwritten by [UnitedHealthcare Insurance Company] ("the Company").

The school (referred to as the "Policyholder") has purchased a Policy from the Company. The Company will provide the benefits described in this Certificate to Insured Persons, as defined in the Definitions section of this Certificate. This Certificate is not a contract between the Insured Person and the Company. Keep this Certificate with other important papers so that it is available for future reference.

[This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of "Preferred Providers." The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as "Out-of-Network Providers." However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

To receive the highest level of benefits from the plan, the Insured Person should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the plan's web site at [www.uhcsr.com]. The web site will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at [1-800-767-0700], toll free, for assistance in finding a Preferred Provider.]

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is [1-800-767-0700]. The Insured can also write to the Company at:

[UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025]

Section 1: Who Is Covered

The Master Policy covers students [and their eligible Dependents] who have met the Policy's eligibility requirements (as shown below) and who:

1. Are properly enrolled in the plan, and
2. Pay the required premium.

[All [registered] [fee-paying] [full-time] [part-time] [degree seeking] [undergraduate] [dormitory] [subsidy/non-subsidy] [supported/unsupported] [graduate] [teaching] [masters] [research] [International] [exchange] [study-abroad] [F-1] [J-1] [non-immigrant International] [medical] [physician assistant] [health science] [nursing] [law] [intern] [pharmacy] [physical therapy] [psychology] [summer] [professional] [social services] [doctorate] [Ph.D] [Ed.D] [post-candidacy doctoral] [post doctorate] [post baccalaureate] [optional practical training] [on-line only degree program] [matriculated] [non-matriculated] [ESL (English as a Second Language)] [curriculum practical training] [insert category of student here] [students] [assistants] [scholars] [visiting scholars] [fellows] [participants] [athletes] [PEL (Program for Experienced Learners) students who are registered for [on-site courses] [or] [courses taken in-residence]] [students registered at an accredited institution of higher learning] [students enrolled in [Intensive English Language courses]] [taking [12] or more credit hours] [who have paid the [student health] fee] [are eligible to enroll [in [Plan [1] [A] of] this insurance plan]] [on a voluntary basis] [are automatically enrolled [in [Plan [1] [A] of] this insurance plan] [at registration]] [are required to purchase [Plan [1] [A] of] this insurance plan] [and the premium for coverage is added to their tuition billing] [for the [9] month school year] [for the summer [semester] [term]][, unless proof of comparable coverage is furnished] [on a mandatory basis] [on a hard-waiver basis].]

[Eligible [students] [participants] [who do enroll] may also insure their Dependents. Eligible Dependents are the student's legal spouse [or Domestic Partner] and dependent children under [26-30] years of age. [See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.]]

[[The student (Named Insured, as defined in this Certificate) must actively attend classes for at least the first [1-45] days after the date for which coverage is purchased.] [[Home study,] [correspondence,] [and] [online] courses do not fulfill the eligibility requirements [that the student actively attend classes].] The Company maintains its right to investigate [eligibility

or] student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.]

[The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse[or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate].
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

[Dependent eligibility expires concurrently with that of the Named Insured.]]

Section 2: Effective and Termination Dates

The Master Policy [on file at the school] becomes effective at 12:01 a.m., [September 1, 2020]. [The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.]

The Master Policy terminates at 11:59 p.m., [September 1, 2021]. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. [Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.]

[For [new] Insureds entering the plan in the [second] [or] [third] [or fourth] [term], coverage is effective [January 1, 2021] [March 1, 2021] [or] [June 1, 2021][, respectively] or the date the enrollment form and full premium are received by the Company (or its authorized representative) whichever is later.]

[If paying premiums [by] [any payment period other than annual, such as semester, quarter, semi-annual, etc.], coverage expires as follows:

[Examples]

[Fall]	[8-15-20]	to	[12-31-20]
[Winter]	[1-1-21]	to	[8-14-21]
[Spring]	[1-1-21]	to	[5-15-21]
[Summer]	[5-16-21]	to	[8-14-21]]

[The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person's premium must be received within [14 – 31] days after the coverage expiration date. [It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.]]

There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces.

The Master Policy is a non-renewable one year term insurance policy. The Master Policy will not be renewed.

[Section [3]: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed [[30-365] days] [[12-24] months] after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.]

[Section [3]: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured incurs Covered Medical Expenses within [30 - 365] days of the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as follows provided the condition continues:

1. When not Hospital Confined on the Termination Date, not to exceed [30-365] days after the Termination Date; or
2. When Hospital Confined on the Termination Date, not to exceed [[30 – 365] days] [[12-24] months] after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

If the Insured is also an insured under the succeeding policy issued to the Policyholder; this Extension of Benefits provision will not apply.]

[Section [4]: Pre-Admission Notification

[The Monitoring Company] should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone [1-877-295-0720] at least five working days prior to the planned admission.

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone [1-877-295-0720] within two working days of the admission to provide notification of any admission due to Medical Emergency.

[The Monitoring Company] is open for Pre-Admission Notification calls from [8:00] a.m. to [6:00] p.m. [C.S.T.], Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling [1-877-295-0720].

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; however, pre-notification is not a guarantee that benefits will be paid.]

[Section [5]: Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. [Preferred Providers in the local school area are:

[List Preferred Providers in School Area here]]

The availability of specific providers is subject to change without notice. A list of Preferred Providers is located on the plan's web site at [www.uhcsr.com]. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling [the Company at [1-800-767-0700]] and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

["Network Area" means the [10 – 50] mile radius around the local school campus the Named Insured is attending.]

[[Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid]. The Company will pay according to the benefit limits in the Schedule of Benefits.]

Inpatient Expenses

Preferred Providers – Eligible Inpatient expenses at a Preferred Provider will be paid at [[50 – 100]%] [the Coinsurance percentages specified in the Schedule of Benefits], up to any limits specified in the Schedule of Benefits. [Preferred

Hospitals include [UnitedHealthcare Options PPO] United Behavioral Health (UBH) facilities.] Call [(800) 767-0700] for information about Preferred Hospitals.

Out-of-Network Providers - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

[Professional & Other Expenses
Benefits for Covered Medical Expenses provided by [name of network or Physician groups] will be paid at [[50 – 100]% of Preferred Allowance] [the Coinsurance percentages specified in the Schedule of Benefits] or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.]

[Special Provider Arrangements
[Affiliated Physicians, Inc. and Doctors Walk-In Clinics] [have] agreed to accept special reduced reimbursement rates for treatment rendered to Insureds. Eligible [Physician] services provided by [Affiliated Physicians, Inc. and Doctors Walk-In Clinics] will be paid at [50 – 100]% of these negotiated rates for Covered Medical Expenses, up to the Schedule of Benefits limits.

Insureds will be responsible for all out of pocket expenses in excess of the Policy limits contained in the Schedule of Benefits.]]

Section [6]: Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available. **Please refer to the attached Schedule of Benefits for benefit details.**

Benefits are payable for Covered Medical Expenses (see Definitions) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance or Copayment amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the Definitions section and the Exclusions and Limitations section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in Exclusions and Limitations. If a benefit is designated, Covered Medical Expenses include:

Inpatient

1. **Room and Board Expense.**
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **[Intensive Care.**
   If provided in the Schedule of Benefits.]

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. **Routine Newborn Care.**

While Hospital Confined and routine nursery care provided immediately after birth. See Benefits for Postpartum Care.

5. **Surgery.**
Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**
Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**
Registered Nurse's services which are all of the following:
- [Private duty nursing care only.]
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

9. **Physician's Visits.**
Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:
- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.

[When these services are performed in a Physician's office, benefits are payable under outpatient Physician's Visits.]

12. **Day Surgery Miscellaneous.**
Facility charge and the charge for services and supplies in connection with outpatient day surgery[; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic].

13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**
Professional services administered in connection with outpatient surgery.

15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. [Benefits do not apply when related to [surgery][or] [Physiotherapy].]

[Benefits include the following services when performed in the Physician's office:

- [Surgery.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]]

Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. [Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.]

See also Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects.

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- The facility charge for use of the emergency room and supplies.
- [The attending Physician's charges.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]
- [Injections.]

[All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.]

18. **Diagnostic X-ray Services.**
[Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.] X-ray services for preventive care are provided as specified under Preventive Care Services.

19. **Radiation Therapy.**
See Schedule of Benefits.

20. **Laboratory Procedures.**
[Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.] Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures.**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections.**
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy.**
See Schedule of Benefits.

24. **Prescription Drugs.**
See Schedule of Benefits.

Other

25. **Ambulance Services.**
See Schedule of Benefits.

26. **Durable Medical Equipment.**
Durable Medical Equipment must be all of the following:
- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment.
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

If more than one piece of equipment or device can meet the Insured's functional need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. [Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year.] No benefits will be paid for rental charges in excess of purchase price.

27. **Consultant Physician Fees.**
Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.
- Treatment of cleft lip and cleft palate.
- [Removal of impacted[wisdom] teeth.]

[Breaking a tooth while eating is not covered.] [Routine dental care and treatment to the gums are not covered.]

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**
See Benefits for Mental Illness and Substance Use Disorders.

30. **Substance Use Disorder Treatment.**
See Benefits for Mental Illness and Substance Use Disorders.

31. **Maternity.**
Same as any other Sickness. See Benefits for Postpartum Care.

32. **Complications of Pregnancy.**
Same as any other Sickness.

33. **Preventive Care Services.**

Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.

36. **[High Cost Procedures.**
The following procedures provided on an outpatient basis:

- CT Scan.
- PET Scan.
- Magnetic Resonance Imaging.]

37. **Home Health Care.**
Services received from a licensed home health agency that are:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.

Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

38. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

Hospice care includes:

- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.

39. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

40. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

41. **Urgent Care Center.**
Benefits are limited to:

- The facility or clinic fee billed by the Urgent Care Center.
- [The attending Physician's charges.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]
- [Injections.]

[All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]

42. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- The facility or clinic fee billed by the Hospital.
- [The attending Physician's charges.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]
- [Injections.]

[All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]

43. **Approved Clinical Trials.**
Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the Policy. Routine patient care costs do not include:
- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for Clinical Trials.

44. **Transplantation Services.**
Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

45. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

46. **Acupuncture in Lieu of Anesthesia.**
See Schedule of Benefits.

47. **Medical Foods.**
Medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical food or low protein modified food products meet all of the following criteria:
- Prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic disease. A written prescription must accompany the claim when submitted.
- Administered under the direction of a Physician.

48. **Medical Supplies.**
Medical supplies must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

49. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

50. **Wigs.**
Wigs and other scalp hair prosthesis when prescribed by a treating oncologist and as a direct result of hair loss due to radiation therapy and/or chemotherapy for cancer.

Section [7]: Mandated Benefits

BENEFITS FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Benefits will be paid as specified in the Policy Schedule of Benefits for the treatment of Mental Illness and Substance Use Disorders subject to all terms and conditions of the Policy and the following limitations.

Covered Medical Expenses will be limited to Inpatient, residential, and outpatient services provided by a Hospital, nonhospital residential facility, outpatient treatment facility, or the office of a Physician, psychologist or independent clinical social worker.

Before an Insured may qualify to receive benefits, a Physician, psychologist, advanced practice registered nurse or independent clinical social worker must:

1. Certify that the individual is suffering from a Mental Illness or Substance Use Disorder and the treatment is medically or psychologically necessary.
2. Prescribe appropriate treatment which may include referral to other treatment providers.

Benefits include the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CHILD HEALTH SCREENING SERVICES

Benefits will be paid the same as any other Sickness for uniform age-appropriate health screening requirements including childhood immunizations, consistent with the standards and schedules of the American Academy of Pediatrics, for Insured's from birth to age 21 years in the District of Columbia and services outside the state for Insured's with special needs.

For the purposes of this benefit, "Insured's with special needs" means an Insured who meets the following criteria:

1. With physical or mental, disabilities or illnesses who resides or receives care in other states, because the District of Columbia does not have the facilities, resources, or services to appropriately treat the Insured's physical or mental, disability or illness.
2. Whose parents or legal guardians reside in the District of Columbia.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy

BENEFITS FOR HABILITATIVE SERVICES FOR THE TREATMENT OF CONGENITAL OR GENETIC BIRTH DEFECTS

Benefits will be paid the same as any other Sickness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects for an Insured Person.

For the purposes of this benefit:

"Congenital or Genetic Birth Defect" means a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder and cerebral palsy.

"Habilitative Services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the Insured Person's ability to function.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR POSTPARTUM CARE

Benefits will be paid the same as any other Sickness for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetricians and Gynecologists, and such coverage must include an in-hospital stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.

Benefits will be provided in all cases of early discharge for post-delivery care within the minimum time periods established above to be delivered in the Insured's home, or, in a Physician's office, as determined by the Physician in consultation with the Insured. The at-home post-delivery care shall be provided by a Physician which includes a registered professional nurse, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

1. Parental education.
2. Assistance and training in breast or bottle feeding.
3. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for colorectal cancer screening for Insured Persons. The screening shall be in compliance with American Cancer Society colorectal cancer screening guidelines, as updated.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CYTOLOGIC SCREENING AND MAMMOGRAPHIC EXAMINATIONS

Benefits will be paid the same as any other Sickness for the following:

1. Annual cervical cytologic screening and cervical cytologic screening for women upon certification by the attending Physician that the test is a Medical Necessity.
2. A baseline mammogram and an annual screening mammogram for women, including 3-D mammogram.
3. Adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening, or molecular breast imaging of the breast, if:
    a. A mammogram demonstrates a Class C or Class D Breast Density Classification.
    b. A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk of cancer as determined by a woman's Physician or advanced practice Registered Nurse.

All such services must be in accordance with the standard practice of medicine.

"Breast density classification" means the four levels of breast density identified in the Breast Imaging Reporting and Data System established by the American College of Radiology, which are:

1. Class A, indicating fatty breast tissue.
2. Class B, indicating scattered fibroglandular breast tissue.
3. Class C, indicating heterogeneously dense breast tissue with fibrous and glandular tissue that are evenly distributed throughout the breast.
4. Class D, indicating extremely dense breast tissue.

Benefits shall not be subject to any Coinsurance or Deductible, but shall be subject to all other limitations and provisions of the Policy

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening in accordance to the latest screening guidelines issued by the American Cancer Society.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR VOLUNTARY HIV SCREENING TEST DURING EMERGENCY ROOM VISIT

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits shall include one emergency department HIV screening test; the cost of administering such test, all laboratory expenses to analyze the test; the cost of communicating to the Insured the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services. Benefits shall not be subject to any Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

1. Conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, other suitable rapid-result test.
2. If the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

BENEFITS FOR CHEMOTHERAPY PILLS

Benefits will be provided for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications. In addition, Insured Persons receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs for those health care services, items or drugs for a Qualified Individual participating in an Approved Clinical Trial if the service, item or drug would have been a Covered Medical Expense had it not been administered in a clinical trial.

"Approved clinical trial" means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare and Medicaid Services.
    e. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group,
    f. and the Community Programs for Clinical Research in AIDS.
    g. The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
2. A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA.
3. An investigational or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Qualified individual" means an Insured who is eligible to participate in an Approved Clinical Trial undertaken for the purposes of prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life threatening illness.

"Routine patient care costs" means:

1. Items, drugs, and services that are typically provided absent a clinical trial.
2. Items, drugs, and services required solely for the provision of the investigational item or service (such as administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.

Routine patient care costs shall not include:

1. The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection or analysis.
2. Items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR TELEHEALTH SERVICES

Benefits will be provided for services delivered through Telehealth on the same basis as services when delivered in person.

"Telehealth" means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of any of the following:

1. Diagnosis.
2. Consultation.

3. Treatment.

Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not considered Telehealth and are not covered services.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR PRESCRIPTION CONTRACEPTIVES

Benefits will be provided for up to a 12 month supply of a prescribed Contraceptive at one time.

Contraceptive means a drug or drug regimen approved by the U.S. Food and Drug Administration to prevent pregnancy.

This benefit does not require additional coverage for Contraceptives that are not covered under the Policy.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, Limitations, or any other provisions of the Policy.

[Section [8]: Excess Provision

[Even if you have other insurance, the plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other [group] insurance.] [Benefits will be paid on the unpaid balances after your other [group] insurance has paid.]

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible [group] insurance [or under an automobile insurance policy].

[However, this Excess Provision will not be applied to the first [$100 - $10,000] of medical expenses incurred.]

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with Policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other [group] insurance does not cover the loss.]

[Section [9]: Coordination of Benefits Provision

Benefits will be coordinated with any other eligible medical, surgical, or hospital Plan or coverage so that combined payments under all programs will not exceed 100% of Allowable Expenses incurred for covered services and supplies.

Definitions

1. **Allowable Expenses:** Any health care expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.
    - The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
    - For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
    - For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
    - If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit

or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admission, and preferred provider arrangements.

2. **Plan:** A form of coverage with which coordination is allowed.

   Plan includes all of the following:
   - Group insurance contracts and subscriber contracts.
   - Uninsured arrangements of group or group-type coverage.
   - Group coverage through closed panel Plans.
   - Group-type contracts, including blanket contracts.
   - The medical care components of long-term care contracts, such as skilled nursing care.
   - The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
   - Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

   Plan does not include any of the following:

   - Hospital indemnity coverage benefits or other fixed indemnity coverage.
   - Accident only coverage.
   - Limited benefit health coverage as defined by state law.
   - Specified disease or specified accident coverage.
   - School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
   - Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
   - Medicare supplement policies.
   - State Plans under Medicaid.
   - A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
   - An Individual Health Insurance Contract.

3. **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.

4. **Secondary Plan:** A Plan that is not the Primary Plan.

5. **We, Us or Our:** The Company named in the Policy.

Rules for Coordination of Benefits - When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are outlined below.

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary. This does not apply to coverage that is

obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Plan to provide out of network benefits.

If the Primary Plan is a closed panel Plan and the Secondary Plan is not a closed panel Plan, the Secondary Plan shall pay or provide benefits as if it were the Primary Plan when an Insured Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Order of Benefit Determination - Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the Plan covering the person as other than a dependent, then the order of benefit is reversed. The Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
   - the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
   - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

3. **Dependent Child/Parents Divorced, Separated or Not Living Together.** If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

   If the specific terms of a court decree state that one of the parents is responsible for the health care services or expenses of the child and that Plan has actual knowledge of those terms, that Plan is Primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's Plan is the Primary Plan. This item shall not apply with respect to any Plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

   If a court decree states that both parents are responsible for the child's health care expenses or coverage, the order of benefit shall be determined in accordance with part (2).

   If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the order of benefits shall be determined in accordance with the rules in part (2).

   If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
   - First, the Plan of the parent with custody of the child.
   - Then the Plan of the spouse of the parent with the custody of the child.
   - The Plan of the parent not having custody of the child.
   - Finally, the Plan of the spouse of the parent not having custody of the child.

4. **Dependent Child/Non-Parental Coverage.** If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.

5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
   - Second, the benefits under the COBRA or continuation coverage.
   - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

If none of the provisions stated above determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.]

[Section [10]: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight
If such Injury shall independently of all other causes and within [90 - 365] days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

[Life	$[500.00 - 25,000.00]
Both Hands, Both Feet, or Sight of Both Eyes	$[500.00 - 25,000.00]
One Hand [and] One Foot	$[500.00 - 25,000.00]
Either One Hand or One Foot and Sight of One Eye	$[500.00 - 25,000.00]
One Hand or One Foot or Sight of One Eye	$[500.00 - 25,000.00]
[Entire Thumb and Index Finger of Either Hand	$[500.00 - 25,000.00]]

Loss shall mean with regard to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.]

[Life	$[500.00 - 25,000.00]
Two or More Members	$[500.00 - 25,000.00]
One Member	$[500.00 - 25,000.00]
[Thumb or Index Finger	$[500.00 - 25,000.00]]

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.]]

[Section [10]: [Accidental] Death Benefit

If an accidental Injury should independently of all other causes [and within [90 - 365] days from the date of Injury solely] result in the loss of the Insured's life, [or if a covered Sickness should result in the loss of the Insured's life,] the Insured's beneficiary may request the Company to pay $[500 – 25,000] in addition to payment under any Medical Expense Benefit provision.]

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required

[STUDENTS ONLY]
[OUTPATIENT SERVICES ONLY]
The student [and Spouse[/Dependents]] [must] [should] use the services of the [Health Center] first where [outpatient] treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the [Student Health Center] for which no prior approval or referral is obtained [are excluded from coverage] [will be subject to [an additional] [a] [$25 - 500] Deductible] [will be paid at [50 - 90%] of the benefits otherwise payable under the Schedule of Benefits]. A referral issued by the [SHC] must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A [SHC] referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. [The student must return to [SHC] for necessary follow-up care].
[2. When the [Student Health Center] is closed.]
[3. When service is rendered at another facility during break or vacation periods.]
[4. Medical care received when the student is more than [10-50 miles] from campus.]
[5. Medical care obtained when a student is no longer able to use the [SHC] due to a change in student status.]
[6.] Maternity, obstetrical and gynecological care.
[7. [Mental Illness treatment] [and] [Substance Use Disorder treatment].]

[[Dependents] [Dependent children] are not eligible to use the [SHC] and therefore are exempt from the above limitations and requirements.]]

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required

[PHYSICIAN'S VISITS]
Insurance benefits for [Physician's visits] are provided only upon referral by the [Student Health Center]. Expenses incurred for [Physician's visits] for which no prior approval or referral is obtained [are excluded from coverage] [will be subject to [an additional] [a] [$25 – 500] Deductible] [will be paid at [50 - 90%] of the benefits otherwise payable under the Schedule of Benefits]. A referral issued by the [SHC] must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A [SHC] referral is not necessary only under any of the following conditions:

1. Medical Emergency. [The student must return to [SHC] for necessary follow-up care].
[2. When the [Student Health Center] is closed.]
[3. When service is rendered at another facility during break or vacation periods.]
[4. Medical care received when the student is more than [10-50 miles] from campus.]
[5. Medical care obtained when a student is no longer able to use the [SHC] due to a change in student status.]

[6.] Maternity, obstetrical and gynecological care.
[7. [Mental Illness treatment] [and] [Substance Use Disorder treatment].]

[[Dependents] [Dependent children] are not eligible to use the [SHC] and therefore are exempt from the above limitations and requirements.]]

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required

[STUDENTS ONLY]
The student [and Spouse[/Dependents]] should use the services of the [Health Center] first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the [Student Health Center] for which no prior approval or referral is obtained will be paid at the Out-of-Network level of benefits as specified in the Schedule of Benefits. A referral issued by the [SHC] must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A [SHC] referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. [The student must return to [SHC] for necessary follow-up care].
[2. When the [Student Health Center] is closed.]
[3. When service is rendered at another facility during break or vacation periods.]
[4. Medical care received when the student is more than [50 miles] from campus.]
[5. Medical care obtained when a student is no longer able to use the [SHC] due to a change in student status.]
[6.] Maternity, obstetrical and gynecological care.
[7. [Mental Illness treatment] [and] [Substance Use Disorder treatment].]

[Dependents [Dependent children] are not eligible to use the [SHC]; and therefore, are exempt from the above limitations and requirements.]]

[Section [12]: Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least [3 - 12] [consecutive months] [one semester] [or] [one quarter] and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than [[30 - 90] days] [[3 – 6] months] under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

[Application must be made and] [P][p]remium must be paid directly to [UnitedHealthcare **Student**Resources] and be received within [14 - 31] days after the expiration date of the Insured's coverage. For further information on the Continuation Privilege, please contact [UnitedHealthcare **Student**Resources].]]

[Section [13]: Dental Benefits

Benefits will be paid for the following specific procedures. Payment will not exceed [the maximum amount specified for each procedure].

[Insert E]

[E] = any dental procedure listed in the "Code for Most Frequently Repeated Dental Procedures" published by the Journal of the American Dental Association.]

[Section [14]: [Student Health Center] - [Routine Foot Care Treatment] (Any service or treatment listed in the Exclusions and Limitations section)

Benefits will be paid for [routine foot care including the care, cutting, and removal of [corns,] [calluses,] [toenails,] and [bunions]] provided that [[the surgery is performed] [the treatment is rendered] at [the Student Health Center]] [or] [the Insured obtains a referral from the Student Health Center for outside treatment]. [The referral issued by the Student Health Center must accompany the claim when submitted.]]

Section [15]: Definitions

ADOPTED [OR FOSTER] CHILD means the adopted child [or foster child] placed with an Insured while that person is covered under the Policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted [or foster] child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

[Benefits will also be provided for another child placed in court-ordered temporary or other custody of the Insured from the moment of placement.]

[The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.]

CIVIL UNION means a same-sex relationship similar like marriage that is recognized by law.

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the Policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the Policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to the Policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

DEPENDENT means the legal spouse (regardless of gender), Civil Union partner, the Named Insured's partner in a recognized, legal marriage entered into in another jurisdiction that is not expressly prohibited or deemed illegal in the District of Columbia [or the Named Insured's Domestic Partner] and their dependent children by blood or by law, including Civil Union partner's children. Children shall cease to be dependent at the end of the month in which they attain the age of [26 – 30] years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
2. Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the Policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

DOMESTIC PARTNER means either: 1) a person who has registered in a state or local domestic partner registry with an Insured Person or 2) each of two people, one of whom is a Named Insured, who has submitted an affidavit to the Policyholder certifying that: (a) each person is 18 years of age; (b) neither person has another domestic partner (or another spouse); and (c) both persons live together in the same residence and intend to do so indefinitely which may be demonstrated by providing valid documentation, such as a joint mortgage or lease, or joint financial statements.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.

Habilitative services do not include Elective Surgery or Elective Treatment or services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis [and major surgery] on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home. Hospital also means a licensed alcohol and drug abuse rehabilitation facility and a mental hospital. Alcohol rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises or on a prearranged basis.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is all of the following:

1. Directly and independently caused by specific accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician within [30 - 365] days after the date of accident.
5. Sustained while the Insured Person is covered under the Policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under the Policy.

INPATIENT REHABILITATION FACILITY means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

INSURED PERSON means: [1)] the Named Insured[; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the Policy, and 2) the appropriate Dependent premium has been paid]. The term Insured also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1. Progressive care.
2. Sub-acute intensive care.
3. Intermediate care units.
4. Private monitored rooms.
5. Observation units.
6. Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1. Death.
2. Placement of the Insured's health in jeopardy.
3. Serious impairment of bodily functions.
4. Serious dysfunction of any body organ or part.
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1. Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2. Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.
3. In accordance with the standards of good medical practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both:

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

The Policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement. The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by this policy.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases* does not mean that treatment of the disorder is a Covered Medical Expense. [If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.]

NAMED INSURED means an eligible, [registered student] [participant] of the Policyholder, if: 1) the [student] [participant] is properly enrolled in the Policy; and 2) the appropriate premium for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

[The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.]

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person’s immediate family.

The term “member of the immediate family” means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

POLICY OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

POLICY YEAR means the period of time beginning on the Policy Effective Date and ending on the Policy Termination Date.

POLICYHOLDER means the institution of higher education to whom the Master Policy is issued.

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under the Policy. [All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness.] [Covered Medical Expenses incurred as a result of an Injury that occurred prior to the Policy’s Effective Date will be considered a sickness under the Policy.]

SKILLED NURSING FACILITY means a Hospital or nursing facility that is licensed and operated as required by law.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases* does not mean that treatment of the disorder is a Covered Medical Expense. [If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.]

URGENT CARE CENTER means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

USUAL AND CUSTOMARY CHARGES means the maximum amount the Policy is obligated to pay for services. Except as otherwise required under state or federal regulations, usual and customary charges will be the lowest of:

1. The billed charge for the services.
2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered.
3. An amount determined using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical difference where applicable, plus a margin factor.

The Company uses data from [FAIR Health, Inc.] [and/or] [Data iSight] to determine Usual and Customary Charges. [Usual and Customary Charges determined using data from FAIR Health, Inc. will be calculated at the [75th – 90th] percentile.] No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Section [16]: Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. [Acne[, except as specifically provided in the Policy].]
2. [Acupuncture, except as specifically provided in the Policy.]
3. [Addiction, such as:
   - [Caffeine addiction.]
   - [Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.]
   - [Codependency.]]
4. [[Conceptual handicap.] [Developmental delay or disorder or mental retardation.] [Learning disabilities.] [Milieu therapy.] [Parent-child problems.]
   [This exclusion does not apply to benefits specifically provided in the Policy.]]
5. [Biofeedback[, except as specifically provided in the Policy].]
6. [Chronic pain disorders.]
7. [Circumcision.]
8. [Cosmetic procedures, except [as specifically provided in the Policy or] reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.]
9. [Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, [college infirmaries] or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.]
10. Dental treatment, except:
    - For accidental Injury to [Sound,] Natural Teeth.
    - For treatment of cleft lip and cleft palate.
    - [As specifically provided in the Schedule of Benefits.]

    This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
11. [Elective Surgery or Elective Treatment.]
12. [Elective abortion.]
13. [Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline[, or chartered aircraft only while participating in a school sponsored [intercollegiate sport][activity]].]
14. [Foot care for the following[, except as specifically provided in the Policy]:
    - [Flat foot conditions.]
    - [Supportive devices for the foot.]

- [Subluxations of the foot.]
- [Fallen arches.]
- [Weak feet.]
- [Chronic foot strain.]
- [Routine foot care including the care, cutting and removal of [corns,] [calluses,] [toenails,] [and] [bunions (except capsular or bone surgery)].]

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.]

15. [Health spa or similar facilities.] [Strengthening programs.]
16. [[Hearing examinations.] [Hearing aids.] Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - [Benefits specifically provided in the Policy.]
    - Hearing screenings specifically provided for in Benefits for Child Health Screening Services.]
17. [Hirsutism.] [Alopecia.]
18. [Hypnosis.]
19. [Immunizations, except as specifically provided in the Policy.] [Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.]
20. [Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.]
21. [Injury or Sickness outside the United States and its possessions[, Canada] [or] [Mexico][, except [for a Medical Emergency] when traveling for [academic study abroad programs,] [business] [or] [pleasure]].]
22. [Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance [in excess of $[500 – 20,000]].]
23. [Injury sustained while:
    - Participating in any [intercollegiate] [or] [professional] sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.]
24. [Injury sustained while:
    - Participating in any contest or competition of intercollegiate [football, etc.].
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.]
25. [Investigational services.]
26. [Lipectomy.]
27. [[Marital] [or] [family] counseling.]
28. [Motor vehicle Injury.]
29. [Nuclear, chemical or biological Contamination, whether direct or indirect. “Contamination” means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death.]
30. [Outpatient Physiotherapy; except when referred by the Student Health Center or as specifically provided in Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects.]
31. [Participation in a riot or civil disorder. Commission of or attempt to commit a felony. [Fighting.]]
32. [Prescription Drugs, services or supplies as follows[, except as specifically provided in the Policy]:
    - [Therapeutic devices or appliances, including: [hypodermic needles,] [syringes,] support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.]
    - [Immunization agents, except as specifically provided in the Policy.]
    - [Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, except as specifically provided in the Policy.]
    - [Products used for cosmetic purposes.]
    - [Drugs used to treat or cure baldness.] [Anabolic steroids used for body building.]
    - [Anorectics - drugs used for the purpose of weight control.]
    - [Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.]
    - [Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.]]
33. [Reproductive services for the following[, except as specifically provided in the Policy]:
    - [Procreative counseling.]
    - [Genetic counseling] [and] [genetic testing].
    - [Cryopreservation of reproductive materials.] [Storage of reproductive materials.]
    - [Fertility tests, except to diagnose the underlying cause of infertility including testing and counseling.]

- [Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.]
- [Premarital examinations.]
- [Impotence, organic or otherwise.]
- [Female sterilization procedures, except as specifically provided in the Policy.]
- [Vasectomy.]
- [Reversal of sterilization procedures.]]

34. [Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except for Covered Medical Expenses incurred in connection with participation in approved clinical trials.]
35. [[Routine eye examinations.] [Eye refractions.] [Eyeglasses.] [Contact lenses.] [Prescriptions or fitting of eyeglasses or contact lenses.] [Vision correction surgery.] [Treatment for visual defects and problems.]
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - [To benefits specifically provided in the Policy.]]
36. [Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.]
37. [Preventive care services which are not specifically provided in the Policy, including:
    - [Routine physical examinations and routine testing.]
    - [Preventive testing or treatment.]
    - [Screening exams or testing in the absence of Injury or Sickness.]]
38. [Services provided [normally without charge] by the Health Service of the Policyholder.] [Services covered or provided by the student health fee.]
39. [[Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia.] [Temporomandibular joint dysfunction, except for surgical treatment.] [Deviated nasal septum, including submucous resection and/or other surgical correction thereof.] [Nasal and sinus surgery, except for treatment of a covered Injury[or treatment of chronic sinusitis].] [This exclusion does not apply to benefits specifically provided in the Policy.]]
40. [Skiing.] [Snowboarding.] [Scuba diving.] [Surfing.] [Roller skating.] [Skateboarding.] [Riding in a rodeo.]
41. [Skydiving.] [Parachuting.] [Hang gliding.] [Glider flying.] [Parasailing.] [Sail planing.] [Bungee jumping.]
42. [Sleep disorders[, except as specifically provided in the Policy].]
43. [Speech therapy, except as specifically provided in the Policy.] [Naturopathic services.]
44. [Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.]
45. [Supplies, except as specifically provided in the Policy.]
46. [Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, [or gynecomastia,] except as specifically provided in the Policy.]
47. [Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
    - [Motorcycle.]
    - [Recreational vehicle including but not limiting to: [two- or three-wheeled motor vehicle,] [four-wheeled all terrain vehicle (ATV),] [jet ski,] [ski cycle,] [or] [snowmobile].]]
48. [Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.]
49. [War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).]
50. [[Weight management.] [Weight reduction.] [Nutrition programs.] [Treatment for obesity [(except [surgery for] morbid obesity)].] [Surgery for removal of excess skin or fat.] This exclusion does not apply to benefits specifically provided in the Policy.]

Section [17]: How to File a Claim for Injury and Sickness Benefits

[In the event of Injury or Sickness, students should:]

1. [Report [to the [Student Health Service] [or] [Infirmary] [for [treatment] [or] [referral]], or when not in school,] to their Physician or Hospital.]
2. [Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the [college] [or] [university] under which the student is insured.] [A Company claim form is not required for filing a claim.]

3. [Secure a Company claim form [from the Student Health Service] [or] [from the address below], [fill in the necessary information,] [have the attending physician complete his portion of the form,] [fill out the form completely,] attach all medical and hospital bills and mail to the address below.] [No claim will be paid unless a Company claim form is filled out completely and mailed to the address below.]
4. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

[UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
[xxx-xxx-xxxx]]

Section [18]: General Provisions

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, [P.O. Box 809025, Dallas, Texas 75380-9025] with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: [Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.] [Claim forms are not required.]

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION AND AUTOPSY: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

Section [19]: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:
1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at [800-767-0700] with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: [UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025].

Internal Appeal Process
Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination.

Upon receipt of the request for an Internal Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within 10 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:
1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:
1. Any new or additional evidence considered by the Company in connection with the grievance; and
2. Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 business days to respond to any new or additional evidence or rationale.

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:
1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company's receipt of the grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
   f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Review (EIR).

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact [Claims Appeals] at [888-315-0447]. The written request for an Expedited Internal Appeal should be sent to: [Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025].

Expedited Internal Review Process

The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

1. Involving Urgent Care Requests; and
2. Related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized

Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance

Office of the Health Care Ombudsman and Bill of Rights
441 4th Street, NW, Suite 250N
Washington, D.C. 20001
Phone: (202) 724-7491
Toll Free: (877) 685-6391
Fax: (202) 442-6724
Email: healthcareombudsman@dc.gov
Website: healthcareombudsman.dc.gov

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases:

Commissioner
Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor
Washington, D.C. 20002
Phone: (202) 727-8000
Fax: (202) 354-1085

RIGHT TO EXTERNAL INDEPENDENT REVIEW

After exhausting the Company's Internal Appeal process, an Insured Person or Authorized Representative may submit a request for an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, or the treatment is determined to be experimental or investigational.

A request for an External Independent Review shall not be made until the Insured Person or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Process shall be considered exhausted if:

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Director. Upon request of an External Review, the Director shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests
All types of External Review requests shall be submitted to the state insurance department at the following address:

Grievance and Appeals Coordinator
Office of the General Counselor
District of Columbia Department of Health
825 North Capital Street, N.E., Room 4119
Washington, D.C. 20002
Phone: 202-442-5979
Fax: 202-442-4797

Standard External Review (SER) Process
A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. Within 5 business days after receiving the SER request notice, the Director will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. After completion of the preliminary review, the Director shall notify the Company, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Director's response shall include what information or materials are needed to make the request complete;
3. If the request is not eligible, the Director's response shall include the reasons for ineligibility. After receiving notice that a request is eligible for SER, the Director shall, within 1 business day:
   a. Assign an Independent Review Organization (IRO) from the Director's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4. a. The Company shall, within 7 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses it decision, the Company shall provide written notification within 1 business day to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 30 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Director. The

Director will forward copies of the recommendation to the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Director at the time the Insured Person receives:
   a. An Adverse Determination if:
      - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      - The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   b. A Final Adverse Determination, if:
      - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
      - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

2. Upon receipt of an EER request, the Director shall immediately send a copy of the request to the Company.
3. Upon receipt of a request for an EER, the Director shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
4. Immediately after completion of the review, the Director shall notify the Company, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
   a. If the request is not complete, the Director's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Director's response shall include the reasons for ineligibility.
5. When a request is complete and eligible for an EER, the Director shall immediately assign an Independent Review Organization (IRO) from the Director's approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
   b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall, make a recommendation to the Director to uphold or reverse the Adverse Determination or Final Adverse Determination.
8. After receipt of the recommendation, the Director shall notify the Company, the Insured Person, and, if applicable, the Authorized Representative.
9. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Company except to the extent the Company has other remedies available under state law. An External Review decision is binding on the Insured Person to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or an Authorized Representative may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Insured Person has already received an External Review decision.

APPEAL RIGHTS DEFINITIONS
For the purpose of this Notice of Appeal Rights, the following terms are defined as shown below:

Adverse Determination means:
1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

Authorized Representative means:
1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Director means the Director, District of Columbia Department of Health.

Evidenced–based Standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Final Adverse Determination means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Prospective Review means Utilization Review performed: 1) prior to an admission or the provision of a health care service or course of treatment; and 2) in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

Retrospective Review means any review of a request for a Covered Medical Expense that is not a Prospective Review request. Retrospective review does not include the review of a claim that is limited to the veracity of documentation or accuracy of coding.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

Questions Regarding Appeal Rights
Contact Customer Service at [1-800-767-0700] with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

DC Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th Street, NW, Suite 250N
Washington, D.C. 20001
Phone: (202) 724-7491
Fax: (202) 442-6724

[Section [20]: Online Access to Account Information

[UnitedHealthcare **Student**Resources] Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to **My Account** at [www.uhcsr.com/myaccount]. Insured students who don't already have an online account may simply select the "Create Account" link. Follow the simple, onscreen directions to establish an online account in minutes using the Insured's 7-digit Insurance ID number or the email address on file.

As part of [UnitedHealthcare **Student**Resources'] environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes a message center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. Notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Profile and making the change there.]

[Section [21]: ID Cards

Digital ID cards will be made available to each Insured Person. The Company will send an email notification when the digital ID card is available to be downloaded from **My Account**. An Insured Person may also use **My Account** to request delivery of a permanent ID card through the mail.]

[Section [22]: UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or the App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. [Covered Dependents are also included.]
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.
- Find My Claims – view claims received within the past 120 days for [both] the primary Insured [and covered Dependents]; includes provider, date of service, status, claim amount and amount paid.]

Section [23]: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

[Administrative Office:
[UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700]
Web site: [www.uhcsr.com]]

[Serviced by:
ABC Agency
123 Avenue
Anytown, USA
1-888-888-8888

Web site: [www.uhcsr.com]]

[Sales/Marketing Services:
[UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
E-mail: info@uhcsr.com]

[Customer Service:
[800-767-0700]
(Customer Services Representatives are available [Monday - Friday, [7:00 a.m. – 7:00 p.m.] (Central Time)])]

Schedule of Benefits

[Policyholder Name]

[Policy Number]

[[Plan 1] [Plan II]]

METALLIC LEVEL – [BRONZE] [SILVER] [GOLD] [PLATINUM] WITH ACTUARIAL VALUE OF [60 – 99]%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible	$[0 - Highest amount allowed under the Affordable Care Act] [(Per Insured Person, Per Policy Year)] [(For each Injury or Sickness)] [The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]
[**Deductible**	$[0 - Highest amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]
Coinsurance	**[**[50 – 100]%] [[50 - 100]% to $[1,000 – 50,000], then [50 - 100%] thereafter] [[50 – 100] % to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter]
Out-of-Pocket Maximum	$[0 – Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (Per Insured Person, Per Policy Year)
[**Out-of-Pocket Maximum**	$[0 – Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]

[The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% up to $[1,000 - 50,000]. After the Company has paid $[1,000 – 50,000], benefits will be paid for additional Covered Medical Expenses incurred at [50 – 100]%.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% up to $[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the $[500 – Highest amount allowed under the Affordable Care Act] Deductible. After the Company pays $[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 - 100]%.]

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year [subject to any benefit maximums or limits that may apply]. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses [and the amount benefits are reduced for failing to comply with Policy provisions or requirements] do not count toward meeting the Out-of-Pocket Maximum.

[Student Health Center Benefits: [The [Deductible] [and] [Copays] will be waived] [and] [benefits will be paid at [100%] [for Covered Medical Expenses incurred] [of billed charges] when treatment is rendered at [or referred by] the Student Health Center] [for the following services: [e.g., any services listed in the schedule of benefits].] [Policy Exclusions and Limitations do not apply.]]

[**Out-of-Country Claims**: Covered Medical Expenses incurred outside the United States will be paid at [50 – 100]% [of] [Usual and Customary Charges] [Coinsurance] [and the Deductible will be waived].]

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. Please refer to the Medical Expense Benefits – Injury and Sickness section in the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	
Room and Board Expense	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Intensive Care	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [Paid under Room & Board] [after Deductible][not subject to Deductible]]
Hospital Miscellaneous Expenses	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Routine Newborn Care See Benefits for Postpartum Care	Paid as any other Sickness
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 1000]% of all subsequent procedures.]	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Anesthetist Services	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Registered Nurse's Services [[10 – 365] days maximum [per Policy Year] [for each Injury or Sickness]]	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [No Benefits]
Physician's Visits	[$[25 – 250] Copay [per visit] [per service]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Pre-admission Testing [Payable within [7 – 14] working days prior to admission.]	[[50 – 100]% of] [Usual and Customary Charges] [Paid under Hospital Miscellaneous Expenses] [after Deductible][not subject to Deductible]

Outpatient	
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Day Surgery Miscellaneous	[$[10 – 1,000] Copay [per date of service]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Anesthetist Services	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Outpatient	
Physician's Visits	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Physiotherapy [Limits [per Policy Year] [for each Injury or Sickness] as follows: [90 – 160] visits of cardiac rehabilitation therapy] [Benefits are payable only when referred by the [Student Health Center].] [Review of Medical Necessity will be performed after [12 – 24] visits per Injury or Sickness.]	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] (See also Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects)
Medical Emergency Expenses [The Copay will be waived if admitted to the Hospital.]	[$[5 – 500] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Diagnostic X-ray Services	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Radiation Therapy	[$[5 – 100] Copay [per treatment] [per visit]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Laboratory Procedures	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Tests & Procedures	[$[5 – 500] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Injections	[$[5 – 50] Copay [per injection] [per visit]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Chemotherapy	[$[5 – 50] Copay [per treatment] [per visit]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Prescription Drugs [*See UHCP Prescription Drug Benefit Endorsement for additional information.]	[[$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0 - 450] Copay per prescription [generic drug]] [$[0 – 450] Copay per prescription brand-name drug] [[50-100]% of] [Usual and Customary Charges [generic drug]] [[50-100]% of] [Usual and Customary Charges brand-name drug] [up to a [30 - 31]-day supply per prescription] [after Deductible][not subject to Deductible]] [*[UnitedHealthcare Pharmacy [(UHCP),]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0-75] Copay per prescription [Tier 1]] [$[0-250] Copay per prescription [Tier 2]]

Outpatient	
	[$[0-450] Copay per prescription [Tier 3]] [$[0-650] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [plus any Ancillary Charge] [up to a [30 - 31]-day supply per prescription] [not subject to Deductible] [When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail [Copay] [and/or] [Coinsurance] (up to 50% of the Prescription Drug Charge).] [Mail order Prescription Drugs [through [UHCP]] [at [2 - 2.5] times the retail Copay[up to a 90-day supply]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0 – 225] Copay per prescription [Tier 1]] [$[0 – 750] Copay per prescription [Tier 2]] [$[0 – 1,350] Copay per prescription [Tier 3]] [$[0 – 1,950] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [plus any Ancillary Charge] [up to a 90-day supply] [not subject to Deductible]] [Out-of-Network Pharmacy: [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0 - 450] Copay per prescription [generic drug]] [$[0 – 450] Copay per prescription brand-name drug] [[50-100]% of] [Usual and Customary Charges [generic drug]] [[50-100]% of] [Usual and Customary Charges brand-name drug] [up to a [30 - 31]-day supply per prescription] [after Deductible][not subject to Deductible]] [No Benefits outside of UnitedHealthcare Pharmacy]]

Other	
Ambulance Services	[$[25 – 1000] Copay [per trip] [per day] [ground] [air]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Durable Medical Equipment	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Consultant Physician Fees	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Other	
Dental Treatment [Benefits paid on Injury to Sound, Natural Teeth and treatment of cleft lip and cleft palate only.]	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness] [No Benefits]
[Dental Treatment Benefits paid for removal of impacted wisdom teeth only.	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [$[50 – 1,500] maximum [per procedure] [per tooth]] [after Deductible][not subject to Deductible]]
Mental Illness Treatment See Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Substance Use Disorder Treatment See Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Maternity See Benefits for Postpartum Care	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness
[Elective Abortion	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Usual and Customary Charges] [$[100 – 1,000] maximum [per Policy Year]] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]]
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied to Preventive Care Services. Please visit [https://www.healthcare.gov/preventive-care-benefits/] for a complete list of services provided for specific age and risk groups.	100% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness
[High Cost Procedures	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]

Other	
Home Health Care	[$[5 – 50] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [[90 – 200] visits maximum per Policy Year] [after Deductible][not subject to Deductible]
Hospice Care	[$[5 – 100] Copay [per day]] [[50-100]% of] [Usual and Customary Charges] [[180 - 220] days maximum per Policy Year] [after Deductible][not subject to Deductible]
Inpatient Rehabilitation Facility	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [[90 – 180] days maximum per Policy Year [after Deductible][not subject to Deductible]
Skilled Nursing Facility	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [[60 – 180] days maximum per Policy Year [after Deductible][not subject to Deductible]
Urgent Care Center	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Hospital Outpatient Facility or Clinic	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Approved Clinical Trials See also Benefits for Clinical Trials	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits
Acupuncture in Lieu of Anesthesia	Paid as any other Sickness
Medical Foods	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Medical Supplies Benefits are limited to a 31 day supply per purchase,	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Ostomy Supplies	[$[5 – 500] Copay [per service or visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Wigs	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Insert any service excluded under the Policy (e.g. Acne)	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [[10 – 100] [days][visits] maximum [per Policy Year] [for each Injury or Sickness]] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]

Other	
[Insert any non-essential service excluded under the Policy (e.g. hearing aids, obesity)	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [[10 – 100] [days] [visits] maximum] [per Policy Year][for each Injury or Sickness] [[$[50 – 10,000] maximum] [per Policy Year][for each Injury or Sickness]] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]

Schedule of Benefits

[Policyholder Name]

[Policy Number]

[Plan I] [Plan II]

METALLIC LEVEL – [BRONZE] [SILVER] [GOLD] [PLATINUM] WITH ACTUARIAL VALUE OF [60 – 99]%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible [Preferred Provider]	$[0 - Highest amount allowed under the Affordable Care Act] [(Per Insured Person, Per Policy Year)] [(For each Injury or Sickness)] [The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]
[Deductible [Preferred Provider]	$[0 - Highest amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]
[Deductible [Out-of-Network]	$[0 - 15,000] [(Per Insured Person, Per Policy Year)] [(For each Injury or Sickness)]] [The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]
[Deductible [Out-of-Network]	$[0 - 45,000] (For all Insureds in a Family, Per Policy Year)]
Coinsurance [Preferred Provider]	[[50 – 100]%] [[50 - 100]% to $[1,000 – 50,000], then [50 - 100%] thereafter] [[50 – 100] % to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter]
Coinsurance [Out-of-Network]	[[50 – 100]%] [[50 - 100]% to $[1,000 – 50,000], then [50 – 100]% thereafter] [[50 – 100]% to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter]
Out-of-Pocket Maximum [Preferred Provider]	$[0 - Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (Per Insured Person, Per Policy Year)
[Out-of-Pocket Maximum [Preferred Provider]	$[0 - Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]
[Out-of-Pocket Maximum [Out-of-Network]	$[0 - 45,000] (Per Insured Person, Per Policy Year)]
[Out-of-Pocket Maximum [Out-of-Network]	$[0 - 45,000] (For all Insureds in a Family, Per Policy Year)]

[The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers [and [50% - 100]% for Out-of-Network Providers] up to $[1,000 - 50,000]. After the Company has paid $[1,000 – 50,000], benefits will be paid for additional Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers [and [50 – 100]% for Out-of-Network Providers].]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers up to $[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the $[500 – Highest amount allowed under the Affordable Care Act] [Preferred Provider] Deductible [and $[500 – 10,000] Out-of-Network Deductible]. After the Company pays $[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 - 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers.]

The [In-Network] [Preferred Provider] for this plan is [University Hospital] [UnitedHealthcare Options PPO].

If care is received [within the Network] [from a Preferred Provider] any Covered Medical Expenses will be paid at the [In-Network] [Preferred Provider] level of benefits. [If [an In-Network] [a Preferred] Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as [In-Network] [Preferred Provider] benefits.] If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the [In-Network] [Preferred Provider] level of benefits. [Covered Medical Expenses incurred at [a Preferred Provider] [an In-Network] facility by an Out-of-Network Provider will be paid at the [Preferred Provider] [In-Network] level of benefits.] [Except for a Medical Emergency, Covered Medical Expenses incurred at [a Preferred Provider] [an In-Network] facility by an Out-of-Network provider will be paid at the Out-of-Network level of benefits.] [In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.]

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year[subject to any benefit maximums or limits that may apply]. [Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits.] [Covered Medical Expenses used to satisfy the Out-of-Pocket Maximum will be applied to both the Preferred Provider and Out-of-Network Out-of-Pocket Maximum.] Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses [and the amount benefits are reduced for failing to comply with Policy provisions or requirements] do not count toward meeting the Out-of-Pocket Maximum. [Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays].

[Student Health Center Benefits: [The [Deductible] [and] [Copays] will be waived] [and] [benefits will be paid at [100%] [for Covered Medical Expenses incurred] [of billed charges] [of the [Preferred Provider] [In-Network] level of benefits] when treatment is rendered at [or referred by] the Student Health Center] [for the following services: [e.g., any services listed in the schedule of benefits].] [Policy Exclusions and Limitations do not apply.]]

[**Out-of-Country Claims:** Covered Medical Expenses incurred outside the United States will be paid at [the [Preferred] [In-Network] Provider level of benefits] [[50 – 100]% [Coinsurance] [of Usual and Customary Charges]] [the Out-of-Network level of benefits] [and the Deductible will be waived].]

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below [All benefit maximums are combined [Preferred Provider] [In-Network] and [Out-of-Network] unless otherwise specifically stated.] Please refer to the Medical Expense Benefits – Injury and Sickness section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Room and Board Expense	[$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Intensive Care	[$[100 – 1,000] Copay per day [to a maximum Copay of [$100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 1,000] Copay per day [to a maximum Copay of [$100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Hospital Miscellaneous Expenses	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Routine Newborn Care See Benefits for Postpartum	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness

Inpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Care			
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Anesthetist Services	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 – 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 – 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Registered Nurse's Services [[10 – 365] days maximum [per Policy Year] [for each Injury or Sickness]]	[[50-100]% of] [Preferred Allowance][after Deductible][not subject to Deductible] [No Benefits]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [No Benefits]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [No Benefits]
Physician's Visits	[$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Pre-admission Testing [Payable within [7 – 14] working days prior to admission.]	[Paid under Hospital Miscellaneous Expenses] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[Paid under Hospital Miscellaneous Expenses] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[Paid under Hospital Miscellaneous Expenses] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Day Surgery Miscellaneous	[$[10 – 1,000] Copay [per date of service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not	[$[10 – 1,000] Copay [per date of service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not	[$[10 - 1,000] Copay [per date of service]] [[50-100]% of] [Usual and Customary Charges]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
	subject to Deductible]	subject to Deductible]	[after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Anesthetist Services	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Physician's Visits	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Physiotherapy [Preferred Provider] [Out-of-Network] [Limits [per Policy Year] [for each Injury or Sickness] as follows: [90 – 160] visits of cardiac rehabilitation therapy] [Benefits are payable only when referred by the [Student Health Center].] [Review of Medical Necessity will be performed after [12 – 24] visits per Injury or Sickness.] See also Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Medical Emergency Expenses [The [Preferred Provider][,] [In-Network][,] [and] [Out-of-Network] Copay will be waived if admitted to the Hospital.]	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 500] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Diagnostic X-ray Services	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Radiation Therapy	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay [per treatment] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Laboratory Procedures	[$[5 – 100] Copay per visit]	[$[5 – 100] Copay per visit]	[$[5 - 100] Copay per visit]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Tests & Procedures	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 500] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Injections	[$[5 – 50] Copay [per injection] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 50] Copay [per injection] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 50] Copay [per injection] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Chemotherapy	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay [per treatment] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Prescription Drugs [The Policy does not include a pharmacy network for Prescription Drugs. All Prescription Drug benefits are payable under the Out-of-Network Provider benefits.] [*See UHCP Prescription Drug Benefit Endorsement for additional information.]	[Not Available] [*[UnitedHealthcare Pharmacy [(UHCP),]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0-75] Copay per prescription [Tier 1]] [$[0 - 250] Copay per prescription [Tier 2]] [$[0 - 450] Copay per prescription [Tier 3]] [$[0 - 650] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge][up to a [30 - 31]-day supply per prescription] [not subject to Deductible] [When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail [Copay] [and/or] [Coinsurance] (up to 50% of the Prescription Drug Charge).]	[Not Available] [*[UnitedHealthcare Pharmacy [(UHCP),]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0-75] Copay per prescription [Tier 1]] [$[0 - 250] Copay per prescription [Tier 2]] [$[0 - 450] Copay per prescription [Tier 3]] [$[0 - 650] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge][up to a [30 - 31]-day supply per prescription] [not subject to Deductible] [When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail [Copay] [and/or] [Coinsurance] (up to 50% of the Prescription Drug Charge).]	[$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0-450] Copay per prescription [generic drug]] [$[0 – 450] Copay per prescription brand-name drug] [[50-100]% of] [Usual and Customary Charges [generic drug]] [[50-100]% of] [Usual and Customary Charges brand-name drug] [up to a [30 - 31]-day supply per prescription] [after Deductible][not subject to Deductible] [No Benefits]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
	[Mail order Prescription Drugs [through [UHCP]] [at [2 - 2.5] times the retail Copay[up to a 90-day supply]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0 - 225] Copay per prescription [Tier 1]] [$[0 - 750] Copay per prescription [Tier 2]] [$[0 – 1,350] Copay per prescription [Tier 3]] [$[0 - 1,950] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [plus any Ancillary Charge] [up to a 90-day supply] [not subject to Deductible]]]	[Mail order Prescription Drugs [through [UHCP]] [at [2 - 2.5] times the retail Copay[up to a 90-day supply]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) does not apply to Policy Deductible] [$[0 - 225] Copay per prescription [Tier 1]] [$[0 - 750] Copay per prescription [Tier 2]] [$[0 – 1,350] Copay per prescription [Tier 3]] [$[0 - 1,950] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [plus any Ancillary Charge] [up to a 90-day supply] [not subject to Deductible]]]	

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Ambulance Services	[$[25 – 1,000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 1,000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 1,000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Durable Medical Equipment	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Consultant Physician Fees	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and treatment of cleft lip and cleft palate only.	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness]	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness]	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness]

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
[Dental Treatment Benefits paid for removal of impacted wisdom teeth only. [$[50 – 1,500] maximum per procedure]	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Mental Illness Treatment	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Substance Use Disorder Treatment	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Maternity See Benefits for Postpartum Care	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
[Elective Abortion [$[100 – 1,000] maximum] [per Policy Year]	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]]
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit [https://www.healthcare.gov/preventive-care-benefits/] for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	[$[5 – 100] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per visit] [per service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [No Benefits]
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
[High Cost Procedures	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Home Health Care [[90 – 200] visits maximum per Policy Year]	[$[5 – 50] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 50] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 50] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Hospice Care [[180 - 220] days maximum per Policy Year]	[$[5 – 100] Copay [per day]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per day]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per day]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Inpatient Rehabilitation Facility [[90 – 180] days maximum per Policy Year]]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Skilled Nursing Facility [[60 – 180] days maximum per Policy Year]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Urgent Care Center	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Hospital Outpatient Facility or Clinic	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Approved Clinical Trials See also Benefits for Clinical Trials	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness	[Paid as any other Sickness] [No Benefits]
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Acupuncture in Lieu of Anesthesia	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Medical Foods	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Medical Supplies Benefits are limited to a 31 day supply per purchase.	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Ostomy Supplies	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Wigs	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
[Insert any service excluded under the Policy (e.g. Acne,) [[10 – 100] [days][visits] maximum [per Policy Year] [for each Injury or Sickness]]	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	[$[5 – 2000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]
[Insert any non-essential service excluded under the Policy (e.g. hearing aids, obesity) [[10 – 100] [days] [visits] maximum] [[$[50 – 10,000] maximum] [per Policy Year][for each Injury or Sickness]	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all of the terms and conditions of the Policy not inconsistent therewith.

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

[UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products when dispensed at a [UHCP] Network Pharmacy as specified in the Policy Schedule of Benefits subject to all terms of the Policy and the provisions, definitions and exclusions specified in this endorsement.

Benefits for Prescription Drug Products are subject to supply limits and Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the Policy Schedule of Benefits for applicable supply limits and Copayments and/or Coinsurance requirements.

Benefit for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Medical Expense.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. [For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.]

The Insured must present their ID card to the Network Pharmacy when the prescription is filled. If the Insured does not present their ID card to the Network Pharmacy, they will need to pay for the Prescription Drug and then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting [www.uhcsr.com] and logging in to their online account [or by calling *Customer Service* at [1-855-828-7716]].

Information on Network Pharmacies is available at [www.uhcsr.com] [or by calling *Customer Service* at [1-855-828-7716]].

[If the Insured does not use a Network Pharmacy, no benefits are available and the Insured will be responsible for paying the full cost for the Prescription Drug.]

[When prescriptions are filled at pharmacies outside a Network Pharmacy, the Insured must pay for the Prescription Drugs out of pocket and submit the receipts for reimbursement as described in the How to File a Claim for Injury and Sickness Benefits section in the Certificate of Coverage.]

[Prescription Drug Deductible

The Insured Person is responsible for paying the Prescription Drug Deductible stated in the Policy Schedule of Benefits before benefits for Prescription Drug Products are available.

The Insured Person is not responsible for paying a Deductible for PPACA Zero Cost Share Preventive Care Medications.]

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lowest of:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

[For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Prescription Drug Charge for that Prescription Drug Product.]

The Insured Person is not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

[When a Prescription Drug Product is dispensed from a mail order Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.]

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may find out whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change. Therefore, the Copayment and/or Coinsurance may change [and an Ancillary Charge may apply,] or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

[Ancillary Charge

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at the Insured Person's [or the Physician's] request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Deductibles or Out-of-Pocket Maximums specified in the Policy Schedule of Benefits.]

Designated Pharmacies

If the Insured requires certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716]. If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, no benefits will be paid for that Prescription Drug Product. For a Specialty Prescription Drug Product, if the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

[Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Insured will receive a 15-day supply of their Specialty Prescription Drug Product to find out if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Insured each time prior to dispensing the 15-day supply to confirm if the Insured is tolerating the Specialty Prescription Drug Product. The Insured may find a list of Specialty Prescription Drug Products included in the Smart Fill Program at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].]

[Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for an Insured Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. The Insured may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program* at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].]

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If the Insured requires Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Specialty Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and the Insured has informed the Company of their decision not to obtain their Specialty Prescription Drug Product from a Designated Pharmacy, and the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

The Company designates certain Network Pharmacies to be Preferred Specialty Network Pharmacies. The Company may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to the Insured unless required by law. The Insured may find out whether a Network Pharmacy is a Preferred Specialty Network Pharmacy at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].

If the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

Please see the Definitions Section for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The following supply limits apply to Specialty Prescription Drug Products.

As written by the Physician, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, [a mail order Network Pharmacy] or a Designated Pharmacy.

[[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to [notify] [obtain prior authorization from] the Company or the Company's designee. The reason for [notifying] [obtaining prior authorization from] the Company is to determine whether the Prescription Drug Product, in accordance with the Company's approved guidelines, is each of the following:

- It meets the definition of a Covered Medical Expense.
- It is not an Experimental or Investigational or Unproven Service.

If [the Company is not notified] [the Insured does not obtain prior authorization from the Company] before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring [notification] [prior authorization] are subject, from time to time, to the Company's review and change. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires [notification] [prior authorization] at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].

If [the Company is not notified] [the Insured does not obtain prior authorization from the Company] before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

When the Insured submits a claim on this basis, the Insured may pay more because they did not [notify] [obtain prior authorization from] the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance[, Ancillary Charge] and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.]

[Step Therapy

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. In order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first.

The Insured may find out whether a Prescription Drug Product is subject to step therapy requirements at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].]

[Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's choice of Network Pharmacies may be limited. If this happens, the Company may require the Insured to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the chosen Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will choose a Network Pharmacy for the Insured.]

Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or [notification] [prior authorization] requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others, therefore; a Prescription Drug may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may happen without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access [www.uhcsr.com] or call *Customer Service* at [1-855-828-7716] for the most up-to-date tier placement.

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they [applied to the Insured's Deductible or] taken into account in determining the Insured's Copayments and/or Coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

Definitions

[**Ancillary Charge** means a charge, in addition to the Copayment and/or Coinsurance, that the Insured must pay when a covered Prescription Drug Product is dispensed at the Insured's [or the Physician's] request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Charge or MAC List price of the Chemically Equivalent Prescription Drug Product.]

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic

based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are a Designated Pharmacy.

[**Experimental or Investigational Services** means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are specifically provided for in the Policy.
- If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the Policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.]

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician will be classified as a Generic by the Company.

[**Maximum Allowable Cost (MAC) List** means a list of Generic Prescription Drug Products that will be covered at a price level that the Company establishes. This list is subject to the Company's review and change from time to time.]

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on the Company's behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is placed on a tier by the Company's PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy means a specialty Network Pharmacy that the Company identifies as a non-preferred pharmacy within the network.

Preferred Specialty Network Pharmacy means a specialty Network Pharmacy that the Company identifies as a preferred pharmacy within the network.

Prescription Drug or Prescription Drug Product means a medication or product that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the Policy, this definition includes:

- Inhalers.
- Insulin.
- [Certain vaccines/immunizations administered in a Network Pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

Prescription Drug Charge means the rate the Company has agreed to pay the Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes a dispensing fee and any applicable sales tax.

Prescription Drug List means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change from time to time. The Insured may find out which tier a particular Prescription Drug Product has been placed at [www.uhcsr.com] or call *Customer Service* at [1-855-828-7716].

Prescription Drug List Management Committee means the committee that the Company designates for placing Prescription Drugs into specific tiers.

Prescription Order or Refill means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

PPACA means Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Insured may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives at [www.uhcsr.com] or by calling *Customer Service* at [1-855-828-7716].

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products at [www.uhcsr.com] or call *Customer Service* at [1-855-828-7716].

[**Therapeutically Equivalent** means when Prescription Drugs Products have essentially the same efficacy and adverse effect profile.]

[**Unproven Service(s)** means services, including medications, that are determined not to be effective for the treatment of the medical condition and/or not to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Company has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Company issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, as it determines, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.]

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes a dispensing fee and any applicable sales tax.

Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. [Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.]
3. [Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.]
4. [Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.]
5. [Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.]
6. [Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-[2] [3] [4].)]
7. [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.]
8. [Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury[, except as required by state mandate].]
9. [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.]
10. [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.]

11. [Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.]
12. [A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.]
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
15. Diagnostic kits and products.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
17. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.

Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call [1-800-767-0700]. The Company will notify the Insured Person of the Company's determination within 72 hours.

Urgent Requests

If the Insured Person's request requires immediate action and a delay could significantly increase the risk to the Insured Person's health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling [1-800-767-0700]. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling [1-800-767-0700] or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

SERFF Tracking #:	*UHLC-132234351*	***State Tracking #:***		***Company Tracking #:***	*COL-17-DC(PY20)POL*

State:	*District of Columbia*	***Filing Company:***	*UnitedHealthcare Insurance Company*
TOI/Sub-TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense/H15G.002 Large Group Only*		
Product Name:	*COL-17-DC (PY20) POL*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Special Notes: Insurance Product/Form Filing
Comments:	
Attachment(s):	DC Readability.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variables
Comments:	
Attachment(s):	COL-17-DC (PY20) POL EOV.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter
Comments:	
Attachment(s):	COL-17-DC (PY20) POL Cover Letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlines for Policy, Certificate, and Schedules
Comments:	
Attachment(s):	COL-17-DC (PY20) POL Redline.pdf COL-17-DC (PY20) CERT Redline.pdf COL-17-DC (PY20) SOB PPO Redline.pdf COL-17-DC (PY20) SOB Redline.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Form Filing List
Comments:	
Attachment(s):	DC 2020 Form Filing List.pdf
Item Status:	
Status Date:	

DISTRICT OF COLUMBIA
READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer: **UnitedHealthcare Insurance Company**
P. O. Box 809025, Dallas, Texas 75380-9025

hereby certifies that this filing complies with Section 35-475 of the District of Columbia Insurance Code and achieves a Flesch reading east test score of 45.7.

Allen Sorbo
President

February 10, 2020
Date

Policy Form Number:

COL-17-DC (PY20) POL, et al.

COL-17-DC (PY20) POL, et al.
Explanation of Variables

The Blanket Student Injury and Sickness Policy is a medical expense student injury and sickness policy that will be issued to various Institutions of Higher Education who will be the master policyholder and whose policy will insure eligible classes of students. Benefit levels and the classes of persons to be insured are determined and negotiated between the policyholder and the company during a bid process. The master policy is a non-renewable one year term policy. Each policy year, which is generally based on an annual school year term, a new contract is negotiated between the company and the policyholder.

The forms comply with all previously enacted PPACA Requirements and the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020; Final Rule as applicable to Student Health Insurance plans issued on or after January 1, 2017.

The coverage under the master policy will be available for students only or students and their eligible dependents. For this reason, all information pertaining to dependent coverage is bracketed as variable. If the master policy is issued for students only, all dependent language would be removed. Coverage will be available as voluntary, mandatory, or mandatory with a right of waiver for any classes of persons to be insured under the master policy as determined by the policyholder.

The forms contain variables to allow the master policyholder to choose the benefit levels and options they will include in the contract for their institution. The deletion of variable (bracketed) material is determined by the benefits accepted by that policyholder for inclusion in the contract. When a full policy is issued, only the relevant variables remain. With the exception of the bracketed numbers and dollar amounts, the bracketed material will either remain in the forms as written, or it will be deleted unless otherwise noted within the Explanation of Variability.

All variables benefit and timeframe ranges are included in the forms. The forms will be issued with amounts or time frames that fall within the ranges. We do, however, retain the right to correct any typographical errors, misspellings, page breaks, and formatting errors that may be identified in the approved forms.

When the master policy is issued to an educational institution, it will include a combination of the following forms which will make up the entire contract.

Going through the forms, the variables are as follows:

POLICY FORM COL-17-DC (PY20) POL

This form includes provisions that apply to the policyholder as part of the contract between the policyholder and the company.

This form will always be included as part of the master policy.

Face Page

- Policyholder Name, Address, Policy Number, Effective Date and Termination Date will be populated with information specific to the institution of higher education.

- Listing of the Forms Attached to and Forming a Part of This Policy will include the names of all applicable forms that will be attached as part of the master policy.

Eligibility

- The standard policy eligibility includes all of the variable language in items 1 and 2. The variables may be removed at the option of the policyholder as determined by the particular institution's eligibility requirements. The school may adjust the length of time the student must attend class to be eligible for the coverage within the variable range. The standard is 31 days.

- The Dependent eligibility information is removed if the policy is issued as student only coverage.

Effective and Termination Dates

- The Dependent information is removed if the policy is issued as student only coverage.

General Provisions

- **BENEFITS:** Dependent coverage information is removed if the policy is issued as student only coverage.
- **PAYMENT OF PREMIUM:** The company address is variable to allow for address changes.

CERTIFICATE OF COVERAGE FORM COL-17-DC (PY20) CERT

This form includes provisions that apply to both the policyholder and the Insured Person as a covered person under the contract between the policyholder and the company.

This form will always be included as part of the master policy.

Cover Page

- [PLAN] is in or out at the option of the policyholder.
- [Designed especially for…] is in or out at the option of the policyholder and if included will list the class of students covered under the plan (i.e. International students).
- Name and location of the school will show the actual policyholder name and location.
- [School Logo/Picture] will be in or out at the option of the policyholder and will contain a picture chosen by the Institution of Higher Education or the school logo.
- The actual policy year for the issued plan will be included with the policy year variable.
- [XX-XXXX-XX] will include the actual policy number.

Table of Contents

The table of contents will be updated based on the final content and page numbers in the certificate.

Introduction

- The variable for [UnitedHealthcare StudentResources] is included or removed at the option of the policyholder.
- The three variable paragraphs explaining the PPO information will be removed if the policy is issued as a Usual and Customary Plan with no Preferred Provider network benefits.
- The variable company contact information allows for updates to the information.

Section 1: Who is Covered

- The variables for student eligibility will include the actual class of student who are eligible to enroll in the plan.
- Bracketed Dependent eligibility text is removed when student only coverage is provided.
- The school determines the length of time the student must attend classes in order to be eligible for the coverage. The standard is 31 days and will match the policy Eligibility. The timeframe can range from 1 to 45 days.
- The school elects to allow home study, correspondence courses, Internet, or television courses to fulfill eligibility requirements. The variables will match the policy Eligibility.

Section 2: Effective and Termination Dates

- The school determines the effective and termination dates based upon the school year start date.
- The variable Dependent language is removed when student only coverage is provided.
- The premium payment expiration language varies according to the method and payment options chosen by the school and is generally based on school terms.

Section [3]: Extension of Benefits after Termination

The school elects within the guidelines of the state requirements if they will provide an Extension of Benefits and which Extension of Benefits they will offer. Only one of the two Extensions shown will be included. Ranges are included for all timeframes, which are determined at the option of the policyholder.

Section [4]: Pre-Admission Notification

Pre-Admission Notification is in our out at the option of the policyholder. Pre-Admission Notification includes a variable to include the name of the company that will administer the notification program. The actual company name will be substituted for [The Monitoring Company]. The telephone number and administration times are variable to allow for updates to the information. Please note, pre-authorization is not required for any policy benefits.

Section [5]: Preferred Provider Information

The Preferred Provider Information section remains in the Certificate when the plan includes Preferred Provider network benefits. This text is removed if the policy is issued as a Usual and Customary Plan with no PPO network benefits.

Going through the section, variables are as follows and may be removed as applicable to the benefit plan:

1. The name of the preferred provider network applicable to the plan will be included in the variable "[Preferred Providers in the local school area are: [List Preferred Providers in School Area here]]"
2. "**Network Area** means the [10 – 50] mile radius around the local school campus the Named Insured is attending" is included only when the Schedule of Benefits includes the following statement, "If [an In-Network] [a Preferred] Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as [In-Network] [Preferred Provider] benefits."
3. If the policy does not have a Deductible, the following variable will be removed: "[[Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid]. The Company will pay according to the benefit limits in the Schedule of Benefits.]"
4. **Preferred Providers** - the actual coinsurance percentage payable will be specified or the following variable will be used if the policy includes tiered or multiple coinsurance levels, "…the Coinsurance percentages specified in the Schedule of Benefits." The variable "Preferred Hospitals include [UnitedHealthcare Options PPO] United Behavioral Health (UBH) facilities" is included when the benefits are provided at UBH facilities. The variable telephone numbers and company contact information allow for updates to the information.
5. **Professional and Other Expenses** – the name of the Preferred Provider will be inserted and the applicable coinsurance designation will remain.
6. **Special Provider Arrangements** will be included if the policy includes a special provider arrangement with a provider near the campus. The variables will be included to match the specialty provider arrangement. The actual name of the affiliated providers will be included where the "[Affiliated Physicians, Inc. and Doctors Walk-In Clinics]" appears.

Section [6]: Medical Expense Benefits – Injury and Sickness

The Medical Expense Benefits correspond to the services and items listed in the Schedule of Benefits. The items that are fully bracketed will be removed if the corresponding Schedule of Benefits line item has been removed; otherwise, they will remain in the Medical Expense Benefits section. The variables within each of the Medical Expense Benefits are explained below and are included or removed at the option of the policyholder.

<u>Inpatient</u>

1. Intensive Care – The benefit description is included if the policy provides a benefit level for Intensive Care that is greater than that provided under the Room and Board benefit. This is at the option of the policyholder.
2. Registered Nurse's Services – The variable for [Private duty nursing care only] is standard to include but may be removed at the option of the policyholder.

<u>Outpatient</u>

1. Surgery – The variable may be removed at the option of the policyholder.
2. Day Surgery Miscellaneous – It is standard to include the variable at the end of the paragraph but it may be removed at the option of the policyholder.
3. Physician's Visits – It is standard to include all of the variables in the first paragraph.
   The variable language, "[Benefits include the following services when performed in the Physician's office: [Surgery.] [X-rays.] [Laboratory procedures.] [Tests and procedures]]," is included only when the policyholder has opted to include these benefits as payable under the Physician's Visit benefit instead of each respective line item benefit. All variables may be removed at the option of the policyholder.
4. Physiotherapy – The speech therapy variable "[Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the

disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules.]" is included as standard. It may be removed at the option of the policyholder.

5. Medical Emergency Expenses – It is standard to remove the variables "[The attending Physician's charges.] [X-rays.] [Laboratory procedures.] [Tests and procedures.] and [Injections.]". These services are generally paid under their respective line items in the Schedule of Benefits. They may be paid under the Medical Emergency Expense benefit at the option of the policyholder and will then remain in the Medical Emergency Benefit description. The last variable paragraph is standard to include.
6. Diagnostic X-Ray Services – It is standard to include the variable option.
7. Laboratory Procedures – It is standard to include the variable option.

Other

1. Durable Medical Equipment – The variable "[Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year.]" is included at the option of the policyholder.
2. Dental Treatment - Any variable option in the benefit description may be removed at the option of the policyholder.
3. High Cost Procedures – This benefit is included at the option of the policyholder to provide a separate benefit level or Copay/Deductible for CT Scan, PET Scan, and Magnetic Resonance Imaging outpatient procedures. When removed, these procedures are paid under their respective line items as listed in the Schedule of Benefits.
4. Urgent Care Center – It is standard to remove the bracketed variables for "[The attending Physician's charges.], [X-rays.], [Laboratory procedures.], [Tests and procedures.], and [Injections.]" These services are generally paid under their respective line items as listed in the Schedule of Benefits. When included in this description, they are paid under the Urgent Care Center benefit at the benefit percentage indicated in the Schedule. The last variable paragraph is standard to include.
5. Hospital Outpatient Facility or Clinic – It is standard to remove the bracketed variables for "[The attending Physician's charges.], [X-rays.], [Laboratory procedures.], [Tests and procedures.], and [Injections.]" These services are generally paid under their respective line items as listed in the Schedule of Benefits. When included in this description, they are paid under this benefit at the benefit percentage indicated in the Schedule. The last variable paragraph is standard to include.

[Section [8]: Excess Provision

The Excess Provision is specifically designed and used for "Excess Only" coverage and is provided at the option of the policyholder. This section would be removed entirely if Excess Only Coverage is not included in the plan.

[Section [9]: Coordination of Benefits Provision

The Coordination of Benefits Provision is provided at the option of the policyholder. This section would be removed entirely if Coordination of Benefits is not included in the plan.

[Section [10]: Accidental Death and Dismemberment Benefits
[Accidental] Death Benefit

At the option of the policyholder, Accidental Death and Dismemberment or just Accidental Death benefits may be provided under the plan. The number of days within which loss must occur can range from 90 to 365 days from the date of Injury. This number is elected by the policyholder. The variables within the Accidental Death and Dismemberment can apply to loss of life only or to a specific combination of losses or a specific number of members lost.

In the [Accidental] Death Benefit, benefits for the loss of the Insured's life can apply to Injury only or to loss of life due to a covered Sickness. The dollar amounts can range from $500 to $25,000. If benefits are elected by the policyholder, only one of the two benefit provisions shown will be included.

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required
[Students Only] [Outpatient Services Only]
[Physician's Visits]
[Students Only]

At the option of the policyholder, the Student Health Center Referral Provisions may be added to require a health center referral requirement. Three options of referral requirements are provided but only one of three provisions shown will be included in the Certificate (if referral is elected by the policyholder).

The "Student Health Center (SHC)" or "University Health Service (UHS)" titles and names within the provisions are bracketed to allow for different references to the health centers used by colleges and universities. In all instances it appears, the name requirement will be changed to match the name used by the policyholder for their specific health center.

The Student Health Center Referral Provisions require a referral for all services except those services or conditions specifically listed in the exception list. The bracketed items are chosen at the option of the policyholder. Dependent references are variable in all three provisions since most student health centers do not provide care for dependents.

- **[Students Only] [Outpatient Services Only]**
  This Student Health Center Referral Provision includes variables, which allows for the following benefit penalties for failure to obtain a referral: 1) benefits excluded from coverage; 2) benefits subject to an additional set dollar Deductible; 3) benefits subject to a Deductible; or 4) benefits to be paid at a [50 -90%] percentage of the benefits otherwise payable under the policy schedule.

- **[Physician's Visits]**
  This Student Health Center Referral Provision requires a referral for specific services only such as "Physician's Visits" as the title indicates. The variable in this instance is any service listed on the Schedule of Benefits that might reasonably require a referral such as physician's visits, x-rays and laboratory procedures, etc.

  This provision also includes variables allowing for the following benefit penalties for failure to obtain a referral: 1) benefits excluded from coverage; 2) benefits subject to an additional set dollar Deductible; or 3) benefits to be paid at a [50 -90%] percentage of the benefits otherwise payable under the policy schedule.

- **[Students Only]**
  This Student Health Center Referral Provision is used with a PPO benefit plan only and pays benefits at the out-of-network level with no referral.

[Section [12]: Continuation Privilege

The Continuation Privilege may be added, at the option of the policyholder, to allow Insured Persons the option to continue coverage under the school's policy in effect for a maximum period that falls with the variable ranges specified in the provision. The provision includes continuous coverage eligibility requirements ranging from a set amount of months, to one semester, or to one quarter.

[Section [13]: Dental Benefits

The Dental Benefits provision may be added, at the option of the policyholder, to provide benefits for specific dental procedures. The name of the dental procedure will be inserted into variable [E] and include any dental procedure listed in the "Code for Most Frequently Repeated Dental Procedures."

[Section [14]: [Student Health Center] – [Routine Foot Care Treatment]
(Any service or treatment listed in the Exclusions and Limitations section)

The Student Health Center [Routine Foot Care Treatment] provision may be included to provide benefits for specific services or treatment excluded under the plan when performed at the Student Health Center or a referral is obtained from the Student Health Center for outside treatment. The requirement for the health center referral to accompany the submitted claim is in or out at the option of the policyholder.

Section [15]: Definitions

1. **Adopted [or Foster] Child:** The adopted child coverage provisions in this definition are always included in policies with student and dependent coverage. Foster child coverage is included at the option of the policyholder.

   In a student only policy, the policyholder may choose not to provide adopted child coverage in which case the entire definition is removed or may choose to provide for the first 31 days after placement. In this case, the first two paragraphs will remain in the definition.

2. **Dependent:** The definition is removed if the policy is issued as a student only policy. The Domestic Partner variable is included only if the policyholder chooses to extend dependent coverage to include domestic partners. The dependent limiting age range is 26 to 30.

3. **Domestic Partner**: The definition is removed if the policy is issued as a student only policy. In a student and dependent policy, domestic partner coverage is a policyholder option. Variable item 4) limits the domestic partner coverage to same sex partners and is included at the option of the policyholder.

4. **Hospital**: The variable "and major surgery" will be removed at the option of the policyholder.

5. **Injury**: The variable range is [30 – 365] days to seek treatment. The policy standard is 30 days. Additional variable may be removed at the option of the policyholder.

6. **Insured Person:** The dependent language is removed for student only policies.

7. **Mental Illness:** The variable information is included as standard but may be removed at the option of the policyholder.

8. **Named Insured**: Either the term registered student or participant is used depending on how the policyholder wants to reference Insureds.

9. **Newborn Infant:** When the policy is issued for student only coverage, the second paragraph is removed since no additional coverage may be purchased for coverage beyond the initial 31 days.

10. **Sickness**: the variable information is included as standard but may be removed at the option of the policyholder.

11. **Substance Use Disorder:** The variable information is included as standard but may be removed at the option of the policyholder.

12. **Usual and Customary Charges:** The FAIR Health, Inc. and Data iSight names are bracketed as one or both companies can be used to determine Usual and Customary charges. Applicable variables will be in or out based on the plan design.

Section [16]: Exclusions and Limitations

All of the Exclusions and Limitations are at the option of the policyholder. The school makes the choice. Any exclusion can remain in its entirety or bracketed items within the exclusion can be removed depending on the benefits of the policy. Bracketed information is included in its entirety or omitted in its entirety with the exception of dollar amounts and time frames which include ranges within the policy.

When exclusion #24 is selected by the policyholder, the variable for "intercollegiate football, etc." will be replaced with the actual sport that will be excluded.

Section [17]: How to File a Claim for Injury and Sickness Benefits

- Instructions for the student to report to the Student Health Service, Infirmary, Physician, or Hospital can be in or out when applicable and based on the plan design and how the school wants to direct the student.
- The policyholder has a choice in requiring claim forms or not.
- The remaining servicing information is variable and is in or out depending on the applicable plan design.
- The variable telephone numbers and company contact information allow for updates to the information.

Section [18]: General Provisions

1. **Notice of Claim:** The company address is variable to allow for a change in address.

2. **Claim Forms**: The requirement for claim forms is variable because the company does not require claim forms to process claims. As a standard, the provision would include the variable "Claim forms are not required." If school requests that claim forms be used, then the "not required" sentence is deleted and the "Upon notice of receipt of claim…" provision is used.

Section [19]: Notice of Appeal Rights

This section is always included in the Certificate. The variable telephone numbers and company contact information allows for updates to the information.

[Section [20]: Online Access to Account Information

Online access to account information section may be added if the policyholder elects to use online access services for its Insureds. The variable company name and website allow for updates to the information.

[Section [21]: ID Cards

This section is included when the policyholder elects to provide ID Cards electronically.

[Section [22]: UHCSR Mobile App

This section is included when the policyholder elects to provide students with access to the UHCSR mobile app.

Section [23]: Important Company Contact Information

The company names, addresses, and telephone numbers are variable to allow for a change in the contact information.

[UNITEDHEALTHCARE PHARMACY (UHCP)] PRESCRIPTION DRUG BENEFITS ENDORSEMENT – OPTIONAL ENDORSMENT

Prescription Drug Benefits are always covered under the master policy.

The [UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Benefits Endorsement, COL-17 (PY20) END RX, is included as part of the master policy and attached to the certificate when UnitedHealthcare network pharmacy benefits are provided. The network name and the contact information are bracketed to allow for flexibility in the provider contact information based on which network is providing the service. All other bracketed text is included in its entirety or omitted in its entirety at the option of the policyholder based on the prescription programs selected.

SCHEDULE OF BENEFITS:
COL-17-DC (PY20) SOB and COL-17-DC (PY20) SOB PPO

The form filing includes two separate Schedules of Benefits. Depending on the type of plan selected by the policyholder, only one of the schedules will be attached to the certificate as part of the master policy. Benefit ranges are included in both schedules for all benefit options.

Schedule COL-17-DC (PY20) SOB provides benefits based on Covered Medical Expenses incurred and does not include Preferred Provider and Out-of-Network benefit differences.

Schedule COL-17-DC (PY20) SOB PPO provides different benefit levels when treatment is received from a Preferred Provider, an In-Network Provider, and / or an Out-of-Network Provider.

In both Schedules, the benefits are variable to allow the policyholder to select the benefit line items and the benefit levels based on their Request for Bid. All required essential benefits are included in the master policy issued.

1. **Schedule Header**
   - The actual Policyholder name, policy number, and plan name will be included at the top of the schedule.
   - The actual plan schedule metallic level (Bronze, Silver, Gold, or Platinum) will be included along with the actuarial value percentage.

2. The **Deductible** variables at the top of the Schedule provide the following options:
   - A policy Deductible that may be applied per insured person an indicated by "[Per Insured Person, Per Policy Year]" or per occurrence as indicated by "[(For each Injury or Sickness)]."

- A Family Deductible may be included with the Per Insured Person Deductible as indicated by "[For all Insureds in a Family, Per Policy Year]."
- A corridor Deductible option can be included and indicated by including "[The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]"
- For 2020, the Deductible amount will never exceed the highest Out-of-Pocket Maximum allowed under 45 CFR 156.130(a), which is $8,150 for student only coverage and $16,300 for family coverage.
- Schedule **COL-17-DC (PY20) SOB PPO** includes variables for separate Preferred Provider, In-Network, and Out-of-Network Deductibles.

3. The **Coinsurance** variables at the top of the Schedule provide the following options:
   - Single coinsurance plan with a range of [50 to 100%].
   - Tiered coinsurance plan with the first tier variable range of [50 – 100]% up to $[1,000 – 50,000], then second tier of [50 – 100]% thereafter.
   - Tiered coinsurance plan with a corridor Deductible. Variable ranges of [50 – 100]% to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter
   - Schedule **COL-17-DC (PY20) SOB PPO** includes variables for separate Preferred Provider and Out-of-Network Coinsurance.
4. The **Out-of-Pocket Maximum** variables at the top of the Schedule provide the following options:
   - A Family Out-of-Pocket Maximum option will be included if the plan provides student and dependent coverage.
   - Schedule **COL-17-DC (PY20) SOB PPO** includes variables for separate Preferred Provider, In-Network, and Out-of-Network Out-of-Pocket Maximums.
   - For 2020, the highest Out-of-Pocket Maximum amount allowed under 45 CFR 156.130(a) is $8,150 for student only coverage and $16,300 for family coverage. In subsequent years, the highest Out-of-Pocket Maximum will be adjusted as allowed by 45 CFR 156.130(a)(2). The policy Out-of-Pocket Maximum will not exceed these amounts.

5. In both schedules, only one of the first three variable paragraphs will be included in the final issued schedule of benefits. When a tiered coinsurance design or the corridor deductible is not included, the first paragraph will be used. When the policy includes a tiered coinsurance design the second paragraph is included. When the policy includes the corridor Deductible, the third paragraph will be included. The variable amounts for the Coinsurance and Deductible will match those at the top of the Schedule when issued.

COL-17-DC (PY20) SOB
[The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% up to $[1,000 - 50,000]. After the Company has paid $[1,000 – 50,000], benefits will be paid for additional Covered Medical Expenses incurred at [50 – 100]%.]

[The Company will pay Covered Medical Expenses incurred at [50 - 100%] up to $[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the $[500 – 10,000] Deductible. After the Company pays $[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 100]%.]

COL-17-DC (PY20) SOB PPO
[The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers [and [50% - 100]% for Out-of-Network Providers] up to $[1,000 - 50,000]. After the Company has paid $[1,000 – 50,000], benefits will be paid for additional Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers [and [50 – 100]% for Out-of-Network Providers].]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers up to $[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the $[500 – 10,000] [Preferred Provider] Deductible [and $[500 – 10,000] Out-of-Network Deductible]. After the Company pays $[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered

Medical Expenses incurred at [50 - 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers.]

6. The **Out-of-Pocket Maximum**. The variables within the paragraph are in or out depending on whether the policy includes any limits, Copays, or Deductibles.

7. The **Student Health Center Benefits** paragraph is included if the policy waives the Deductible and Copays or provides a higher benefit level for all services or only specified services when treatment is provided at or referred by the Student Health Center. Variable options are indicated in the paragraph.

8. The **Out of Country Claims** paragraph is included when the policy will pay out of country benefits at a different benefit level than claims incurred in the United States. Variable benefit options are indicated in the paragraph.

9. Schedule **COL-17-DC (PY20) SOB PPO** Preferred Provider Payment Information paragraph (located above the Out-of-Pocket maximum paragraph):

   The Preferred Provider Schedule of Benefits is issued as standard with Preferred Provider and Out-of-Network Benefits, and all of the references to In-Network are removed. Occasionally, a school has a special arrangement with a hospital or provider group that is affiliated with the school that provides a discount for students, such as a university teaching hospital. In that event, the policy could provide 100% coverage at that provider, [50 to 90]% for any other In-Network Providers and [50 to 90]% for Out-of-Network Providers. The bracketed text at the top of the schedule allows for use of the term Preferred Provider, In-Network, or Out-of-Network as it would apply for the particular school.

   The [In-Network] [Preferred Provider] designation paragraph includes the actual name of the Preferred Provider associated with the plan (and In-Network Providers, if applicable).

   The following variables are available at the option of the policyholder:
   - [If [an In-Network] [a Preferred] Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as [In-Network] [Preferred Provider] benefits.]
   - [Covered Medical Expenses incurred at [a Preferred Provider] [an In-Network] facility by an Out-of-Network Provider will be paid at the [Preferred Provider] [In-Network] level of benefits.]
   - [Except for a Medical Emergency, Covered Medical Expenses incurred at [a Preferred Provider] [an In-Network] facility by an Out-of-Network provider will be paid at the Out-of-Network level of benefits.] [In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.]

10. All line item benefits include variable ranges. Variables are included for Deductibles / Copays / maximums as indicated on each line item. If a benefit is not provided, all fully bracketed schedule items may be removed from the Schedule of Benefits or may be designated as “No Benefits” as indicated by the variability.

UnitedHealthcare®

StudentResources
1311 W. President George Bush Hwy, 3rd Floor
Richardson, TX 75080
1-888-767-0700

February 10, 2020

Honorable Karima Woods
Commissioner of Insurance
District of Columbia Department of Insurance
810 First Street, NE, Suite #701
Washington, DC 20002

RE: UnitedHealthcare Insurance Company - NAIC# 79413 SERFF # UHLC-132234351
Blanket Student Injury and Sickness Insurance

Form Numbers:
COL-17-DC (PY20) POL et al (Please refer to form filing list for complete list of forms)

Dear Commissioner Woods:

Enclosed for your consideration and approval is our original submission of the above referenced blanket student injury and sickness forms. The forms are revised versions of previously approved forms as described below.

Revisions have been made to the Policy, Certificate of Coverage, [UnitedHealthcare Network Pharmacy (UHCP)] Prescription Drug Benefits Endorsement, and Schedule(s) of Benefits to create (PY20) versions. The revisions are being made due to regulatory and administrative changes as described below and will be used beginning with the 2020-2021 academic policy year.

Policy Form COL-17-DC (PY20) POL
This form will replace form COL-17-DC POL approved on March 8, 2017, under SERFF Submission # UHLC-130812682. The changes are as follows:

1. Modified the face page to reference Policy attachments by name instead of form number.
2. Made administrative updates such as date updates and bracketing corrections to aid with issue of the form.

Certificate of Coverage Form COL-17-DC (PY20) CERT
This form will replace form COL-17-DC (PY19) CERT approved on June 26, 2019, under SERFF Submission # UHLC-131911323. The changes are as follows:

1. Modified the Mandated Benefit[s] for Mental Illness and Substance Use Disorders to clarify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
2. Revised the Reproductive/Infertility exclusion for clarity on page 25.
3. Revised the Ombudsman's Office address in our Notice of Appeal Rights section on page 30.
4. Made administrative updates to aid with issue of the form.

[UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Endorsement Form COL-17-DC (PY20) END RX
This form will replace form COL-17 END RX approved on March 8, 2017, under SERFF Submission # UHLC-130812682. The changes are as follows:

1. Added refill dispensing requirements for certain controlled medications.
2. Made administrative updates to remove "through the Internet" and "[the telephone number on the Insured's ID card]."
3. Added a description of the Prescription Drug Deductible option.
4. Changed the title of the definition of Preventive Care Medications to PPACA Zero Cost Share Preventive Care Medications. Also revised the text of this definition.
5. Added variables to the Notification requirements sections to allow for either reference to Notification or Prior Authorization.
6. Added the following exclusion as the final exclusion in the endorsement. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
7. Made additional language updates to aid with administration and issue of the form.

Schedule of Benefits Forms COL-17-DC (PY20) SOB PPO and COL-17-DC (PY20) SOB
These forms will replace forms COL-17-DC SOB PPO and COL-17-DC SOB approved on March 8, 2017, under SERFF Submission # UHLC-130812682. The changes are as follows:

1. Removed the Copays variable paragraph from the top of the Schedule.
2. Added a variable paragraph pertaining to Covered Medical Expenses incurred outside the United States to the top of the Schedule.
3. Added variables for [after Deductible] and [not subject to Deductible] to most line item services.
4. PPO Schedule – added [Not Available] to the Preferred Provider and [In-Network Provider] Prescription Drug benefits for use when the plan does not utilize a pharmacy network for prescription drug benefits.
5. Made additional administrative changes to the prescription drug benefit variables.
6. Modified the Mental Illness Treatment and Substance Use Disorder Treatment benefits to clarify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Redline versions of the revised forms are attached in the supporting documents tab within this new SERFF filing.
We will continue to use the following previously approved forms with the revised forms included in this submission. These forms remain the same as the previously approved versions:

Form	**SERFF Submission/Approval**
COL-17 END PEDDENT	UHLC-130812682 / Approved March 8, 2017
COL-17 END PEDVIS	UHLC-130812682 / Approved March 8, 2017
COL-17-DC (PY18) END RME	UHLC-131411016 / Approved May 23, 2018
COL-17-(PY19) END RMESPN	UHLC-131911323 / Approved June 26, 2019
COL-17 –DC AP1	UHLC-130812682 / Approved March 8, 2017

Applicable forms are being filed concurrently in our domiciliary state of Connecticut.

Also enclosed is the required readability certification, and filing forms for approval. Please note our corresponding rate filing will be filed under separate SERFF Filing # UHLC-132234352 once finalized by our Actuarial Department. It is understood this form filing will be "Closed" by your Department until the rate filing is approved.

We appreciate your prompt review and approval of this form. Feel free to contact me if you have any questions or if you require further information. You may call me toll-free at (866) 808-8305, extension 36382. You may also email me directly at mwenshau@uhcsr.com.

Sincerely,

Mark Wenshau, HIA, HIPAAA
Compliance Analyst
UnitedHealthcare **Student**Resources

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office Address: P. O. Box 809025, Dallas, Texas 75380-9025

Blanket Student Accident and Sickness Policy

POLICYHOLDER	[Any School]	**POLICY NUMBER**	[~~17~~20-00000-00]
ADDRESS	[123 Any Street]	**Effective Date**	[8-1-~~2017~~2020] at 12:01 a.m.
	[Any City, District of Columbia]	**Termination Date**	[7-31-~~2018~~2021] at 11:59 p.m.

PREMIUM FOR EACH INSURED PERSON

See Application Attached

LIST OF FORMS ATTACHED TO AND FORMING A PART OF THIS POLICY

~~COL-17-DC AP1~~Policyholder Application
~~COL-17-DC CERT~~Certificate of Coverage
~~[COL-17-DC SOB PPO]~~
~~[COL-17-DC SOB]~~Schedule of Benefits
~~COL-17 END PEDDENT~~Pediatric Dental Services Benefits Policy Endorsement
~~COL-17 END PEDVIS~~Pediatric Vision Care Services Benefit Policy Endorsement
[[~~COL-17 END RX~~UnitedHealthcare Pharmacy (UHCP)] Prescription Drug Benefits Policy Endorsement]
[Assistance and Evacutaion Benefits Policy Endorsement]

UNITEDHEALTHCARE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this Policy, including the attached forms, to pay the benefits provided by this Policy for loss resulting from a cause covered by this Policy. This Policy is issued in consideration of the application and payment of the premiums as specified in the application. Premiums are payable for each Insured Person.

Non-Renewable One Year Term Insurance – This Policy Will Not Be Renewed

President

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this Policy at any time up to the later of: 1) two years after the termination of this Policy; and 2) the date of final adjustment and settlement of all claims under this Policy.

Eligibility

Each person who belongs to one of the "Classes of Persons to be Insured" as set forth in the Policyholder application is eligible to be insured under this Policy.

1. [[The Named Insured must actively attend classes for at least the first [1-45] days after the date for which coverage is purchased.]
2. [[Home study,] [correspondence,] [and] [online] courses do not fulfill the eligibility requirements[that the Named Insured actively attend classes].]

The Company maintains its right to investigate [eligibility or] student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.]

[The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse[or Domestic Partner who meets the specific requirements set forth in the “Definitions” section of this Policy].
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the "Definitions" section of this Policy.

[Dependent eligibility expires concurrently with that of the Named Insured.]]

Eligible persons may be insured under this Policy subject to ~~the~~ all of the following:

1. Payment of premium as set forth on the Policy application.
2. Application to the Company for such coverage.

Effective and Termination Dates

Effective Date: Insurance under this Policy shall become effective on the later of the following dates:

1. The Effective Date of the Policy.
2. The date premium is received by the Administrator.
3. With respect to coverage for the Named Insured, the first day of the period for which premium is paid.

[Dependent coverage will not be effective prior to that of the Named Insured.]

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1. The last day of the period through which the premium is paid.
2. The date the Policy terminates.

[The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

1. The last day of the period through which the premium is paid.
2. The date the Policy terminates.
3. [The date the Named Insured's coverage terminates.]]

General Provisions

BENEFITS: The Named Insured [and any enrolled Dependents] are entitled to benefits for Covered Medical Expenses subject to the terms, conditions, limitations and exclusions set forth in the Certificate of Coverage, Schedule of Benefits, and any Endorsements or amendments attached to this Policy. Each Certificate of Coverage and Schedule of Benefits, including any Endorsements or amendments, describes the Covered Medical Expenses and the terms, conditions, limitations and exclusions related to coverage.

ENTIRE CONTRACT CHANGES: This Policy, including the Certificate of Coverage, Schedule of Benefits, Endorsements, Policyholder Application, and attached papers, if any, shall constitute the entire contract between the parties. No agent has authority to change this Policy or to waive any of its provisions. No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an Endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each Policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the Policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the Policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, [P.O. Box 809026, Dallas, Texas 75380-9026].

INDIVIDUAL CERTIFICATES: A Certificate of Coverage, including a Schedule of Benefits and any attachments, will be available: 1) to the Policyholder for delivery to the Named Insured; or 2) directly to the Named Insured.

The Certificate sets forth: 1) an Insured Person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided; and 2) to whom the insurance benefits are payable.

CONFORMITY WITH STATUTES: Any provisions of this policy which, on the Effective Date of Coverage, are in conflict with the statues of the state of issue on that date are amended to conform to such statutes. The state of issue is shown on the policy face page.

UNITEDHEALTHCARE INSURANCE COMPANY

BLANKET STUDENT ACCIDENT AND SICKNESS [PLAN]

CERTIFICATE OF COVERAGE

[Designed Especially for [the [Insert Category of Student Here] [Students] of]]

[ANY [UNIVERSITY]]
[Any town, DC]
[School Logo / Picture]

[~~2019~~2020-~~2020~~2021]

This Certificate of Coverage is Part of Policy # [XX-XXXX-XX]

This Certificate of Coverage ("Certificate") is part of the contract between UnitedHealthcare Insurance Company (hereinafter referred to as the "Company") and the Policyholder.

Please keep this Certificate as an explanation of the benefits available to the Insured Person under the contract between the Company and the Policyholder. This Certificate is not a contract between the Insured Person and the Company. Amendments or endorsements may be delivered with the Certificate or added thereafter. The Master Policy is on file with the Policyholder and contains all of the provisions, limitations, exclusions, and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

Table of Contents

Introduction

Welcome to the [UnitedHealthcare StudentResources] Student Injury and Sickness Insurance Plan. This plan is underwritten by [UnitedHealthcare Insurance Company] ("the Company").

The school (referred to as the "Policyholder") has purchased a Policy from the Company. The Company will provide the benefits described in this Certificate to Insured Persons, as defined in the Definitions section of this Certificate. This Certificate is not a contract between the Insured Person and the Company. Keep this Certificate with other important papers so that it is available for future reference.

[This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of "Preferred Providers." The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as "Out-of-Network Providers." However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

To receive the highest level of benefits from the plan, the Insured Person should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the plan's web site at [www.uhcsr.com]. The web site will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at [1-800-767-0700], toll free, for assistance in finding a Preferred Provider.]

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is [1-800-767-0700]. The Insured can also write to the Company at:

[UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025]

Section 1: Who Is Covered

The Master Policy covers students [and their eligible Dependents] who have met the Policy's eligibility requirements (as shown below) and who:

1. Are properly enrolled in the plan, and
2. Pay the required premium.

[All [registered] [fee-paying] [full-time] [part-time] [degree seeking] [undergraduate] [dormitory] [subsidy/non-subsidy] [supported/unsupported] [graduate] [teaching] [masters] [research] [International] [exchange] [study-abroad] [F-1] [J-1] [non-immigrant International] [medical] [physician assistant] [health science] [nursing] [law] [intern] [pharmacy] [physical therapy] [psychology] [summer] [professional] [social services] [doctorate] [Ph.D] [Ed.D] [post-candidacy doctoral] [post doctorate] [post baccalaureate] [optional practical training] [on-line only degree program] [matriculated] [non-matriculated] [ESL (English as a Second Language)] [curriculum practical training] [insert category of student here] [students] [assistants] [scholars] [visiting scholars] [fellows] [participants] [athletes] [PEL (Program for Experienced Learners) students who are registered for [on-site courses] [or] [courses taken in-residence]] [students registered at an accredited institution of higher learning] [students enrolled in [Intensive English Language courses]] [taking [12] or more credit hours] [who have paid the [student health] fee] [are eligible to enroll [in [Plan [1] [A] of] this insurance plan]] [on a voluntary basis] [are automatically enrolled [in [Plan [1] [A] of] this insurance plan] [at registration]] [are required to purchase [Plan [1] [A] of] this insurance plan] [and the premium for coverage is added to their tuition billing] [for the [9] month school year] [for the summer [semester] [term]][, unless proof of comparable coverage is furnished] [on a mandatory basis] [on a hard-waiver basis].]

[Eligible [students] [participants] [who do enroll] may also insure their Dependents. Eligible Dependents are the student's legal spouse [or Domestic Partner] and dependent children under [26-30] years of age. [See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.]]

[[The student (Named Insured, as defined in this Certificate) must actively attend classes for at least the first [1-45] days after the date for which coverage is purchased.] [[Home study,] [correspondence,] [and] [online] courses do not fulfill the eligibility requirements [that the student actively attend classes].] The Company maintains its right to investigate [eligibility

or] student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.]

[The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse[or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate].
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

[Dependent eligibility expires concurrently with that of the Named Insured.]]

Section 2: Effective and Termination Dates

The Master Policy [on file at the school] becomes effective at 12:01 a.m., [September 1, ~~2017~~2020]. [The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.]

The Master Policy terminates at 11:59 p.m., [September 1, ~~2018~~2021]. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. [Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.]

[For [new] Insureds entering the plan in the [second] [or] [third] [or fourth] [term], coverage is effective [January 1, ~~2018~~2021] [March 1, ~~2018~~2021] [or] [June 1, ~~2018~~2021][, respectively] or the date the enrollment form and full premium are received by the Company (or its authorized representative) whichever is later.]

[If paying premiums [by] [any payment period other than annual, such as semester, quarter, semi-annual, etc.], coverage expires as follows:

[Examples]

[Fall]	[8-15-~~19~~20]	to	[12-31-~~19~~20]
[Winter]	[1-1-~~20~~21]	to	[8-14-~~20~~21]
[Spring]	[1-1-~~20~~21]	to	[5-15-~~20~~21]
[Summer]	[5-16-~~20~~21]	to	[8-14-~~20~~21]]

[The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person's premium must be received within [14 – 31] days after the coverage expiration date. [It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.]]

There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces.

The Master Policy is a non-renewable one year term insurance policy. The Master Policy will not be renewed.

[Section [3]: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed [[30-365] days] [[12-24] months] after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.]

[Section [3]: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured incurs Covered Medical Expenses within [30 - 365] days of the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as follows provided the condition continues:

1. When not Hospital Confined on the Termination Date, not to exceed [30-365] days after the Termination Date; or
2. When Hospital Confined on the Termination Date, not to exceed [[30 – 365] days] [[12-24] months] after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

If the Insured is also an insured under the succeeding policy issued to the Policyholder; this Extension of Benefits provision will not apply.]

[Section [4]: Pre-Admission Notification

[The Monitoring Company] should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone [1-877-295-0720] at least five working days prior to the planned admission.

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone [1-877-295-0720] within two working days of the admission to provide notification of any admission due to Medical Emergency.

[The Monitoring Company] is open for Pre-Admission Notification calls from [8:00] a.m. to [6:00] p.m. [C.S.T.], Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling [1-877-295-0720].

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; however, pre-notification is not a guarantee that benefits will be paid.]

[Section [5]: Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. [Preferred Providers in the local school area are:

[List Preferred Providers in School Area here]]

The availability of specific providers is subject to change without notice. A list of Preferred Providers is located on the plan's web site at [www.uhcsr.com]. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling [the Company at [1-800-767-0700]] and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

["Network Area" means the [10 – 50] mile radius around the local school campus the Named Insured is attending.]

[[Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid]. The Company will pay according to the benefit limits in the Schedule of Benefits.]

Inpatient Expenses

Preferred Providers – Eligible Inpatient expenses at a Preferred Provider will be paid at [[50 – 100]%] [the Coinsurance percentages specified in the Schedule of Benefits], up to any limits specified in the Schedule of Benefits. [Preferred

Hospitals include [UnitedHealthcare Options PPO] United Behavioral Health (UBH) facilities.] Call [(800) 767-0700] for information about Preferred Hospitals.

Out-of-Network Providers - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

[Professional & Other Expenses
Benefits for Covered Medical Expenses provided by [name of network or Physician groups] will be paid at [[50 – 100]% of Preferred Allowance] [the Coinsurance percentages specified in the Schedule of Benefits] or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.]

[Special Provider Arrangements
[Affiliated Physicians, Inc. and Doctors Walk-In Clinics] [have] agreed to accept special reduced reimbursement rates for treatment rendered to Insureds. Eligible [Physician] services provided by [Affiliated Physicians, Inc. and Doctors Walk-In Clinics] will be paid at [50 – 100]% of these negotiated rates for Covered Medical Expenses, up to the Schedule of Benefits limits.

Insureds will be responsible for all out of pocket expenses in excess of the Policy limits contained in the Schedule of Benefits.]]

Section [6]: Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available. **Please refer to the attached Schedule of Benefits for benefit details.**

Benefits are payable for Covered Medical Expenses (see Definitions) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance or Copayment amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the Definitions section and the Exclusions and Limitations section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in Exclusions and Limitations. If a benefit is designated, Covered Medical Expenses include:

Inpatient

1. **Room and Board Expense.**
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **[Intensive Care.**
   If provided in the Schedule of Benefits.]

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. **Routine Newborn Care.**

While Hospital Confined and routine nursery care provided immediately after birth. See Benefits for Postpartum Care.

5. **Surgery.**
Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**
Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**
Registered Nurse's services which are all of the following:
- [Private duty nursing care only.]
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

9. **Physician's Visits.**
Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:
- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.

[When these services are performed in a Physician's office, benefits are payable under outpatient Physician's Visits.]

12. **Day Surgery Miscellaneous.**
Facility charge and the charge for services and supplies in connection with outpatient day surgery[; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic].

13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**
Professional services administered in connection with outpatient surgery.

15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. [Benefits do not apply when related to [surgery][or] [Physiotherapy].]

[Benefits include the following services when performed in the Physician's office:

- [Surgery.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]]

Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. [Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.]

See also Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects.

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- The facility charge for use of the emergency room and supplies.
- [The attending Physician's charges.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]
- [Injections.]

[All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.]

18. **Diagnostic X-ray Services.**
[Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.] X-ray services for preventive care are provided as specified under Preventive Care Services.

19. **Radiation Therapy.**
See Schedule of Benefits.

20. **Laboratory Procedures.**
[Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.] Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures.**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections.**
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy.**
See Schedule of Benefits.

24. **Prescription Drugs.**
See Schedule of Benefits.

Other

25. **Ambulance Services.**
See Schedule of Benefits.

26. **Durable Medical Equipment.**
Durable Medical Equipment must be all of the following:
- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment.
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

If more than one piece of equipment or device can meet the Insured's functional need, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. [Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year.] No benefits will be paid for rental charges in excess of purchase price.

27. **Consultant Physician Fees.**
Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.
- Treatment of cleft lip and cleft palate.
- [Removal of impacted[wisdom] teeth.]

[Breaking a tooth while eating is not covered.] [Routine dental care and treatment to the gums are not covered.]

Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. **Mental Illness Treatment.**
See Benefits for Mental Illness and Substance Use Disorders.

30. **Substance Use Disorder Treatment.**
See Benefits for Mental Illness and Substance Use Disorders.

31. **Maternity.**
Same as any other Sickness. See Benefits for Postpartum Care.

32. **Complications of Pregnancy.**
Same as any other Sickness.

33. **Preventive Care Services.**

Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.

36. **[High Cost Procedures.**
The following procedures provided on an outpatient basis:

- CT Scan.
- PET Scan.
- Magnetic Resonance Imaging.]

37. **Home Health Care.**
Services received from a licensed home health agency that are:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.

Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

38. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

Hospice care includes:

- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.

39. **Inpatient Rehabilitation Facility.**
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

40. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

41. **Urgent Care Center.**
Benefits are limited to:

- The facility or clinic fee billed by the Urgent Care Center.
- [The attending Physician's charges.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]
- [Injections.]

[All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]

42. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- The facility or clinic fee billed by the Hospital.
- [The attending Physician's charges.]
- [X-rays.]
- [Laboratory procedures.]
- [Tests and procedures.]
- [Injections.]

[All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]

43. **Approved Clinical Trials.**
Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the Policy. Routine patient care costs do not include:
- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for Clinical Trials.

44. **Transplantation Services.**
Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

45. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

46. **Acupuncture in Lieu of Anesthesia.**
See Schedule of Benefits.

47. **Medical Foods.**
Medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical food or low protein modified food products meet all of the following criteria:
- Prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic disease. A written prescription must accompany the claim when submitted.
- Administered under the direction of a Physician.

48. **Medical Supplies.**
Medical supplies must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

49. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

50. **Wigs.**
Wigs and other scalp hair prosthesis when prescribed by a treating oncologist and as a direct result of hair loss due to radiation therapy and/or chemotherapy for cancer.

Section [7]: Mandated Benefits

BENEFITS FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Benefits will be paid as specified in the Policy Schedule of Benefits~~the same as any other Sickness~~ for the treatment of Mental Illness and Substance Use Disorders subject to all terms and conditions of the Policy and the following limitations.

Covered Medical Expenses will be limited to Inpatient, residential, and outpatient services provided by a Hospital, nonhospital residential facility, outpatient treatment facility, or the office of a Physician, psychologist or independent clinical social worker.

Before an Insured may qualify to receive benefits, a Physician, psychologist, advanced practice registered nurse or independent clinical social worker must:

1. Certify that the individual is suffering from a Mental Illness or Substance Use Disorder and the treatment is medically or psychologically necessary.
2. Prescribe appropriate treatment which may include referral to other treatment providers.

Benefits include the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CHILD HEALTH SCREENING SERVICES

Benefits will be paid the same as any other Sickness for uniform age-appropriate health screening requirements including childhood immunizations, consistent with the standards and schedules of the American Academy of Pediatrics, for Insured's from birth to age 21 years in the District of Columbia and services outside the state for Insured's with special needs.

For the purposes of this benefit, "Insured's with special needs" means an Insured who meets the following criteria:

1. With physical or mental, disabilities or illnesses who resides or receives care in other states, because the District of Columbia does not have the facilities, resources, or services to appropriately treat the Insured's physical or mental, disability or illness.
2. Whose parents or legal guardians reside in the District of Columbia.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy

BENEFITS FOR HABILITATIVE SERVICES FOR THE TREATMENT OF CONGENITAL OR GENETIC BIRTH DEFECTS

Benefits will be paid the same as any other Sickness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects for an Insured Person.

For the purposes of this benefit:

"Congenital or Genetic Birth Defect" means a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder and cerebral palsy.

"Habilitative Services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the Insured Person's ability to function.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR POSTPARTUM CARE

Benefits will be paid the same as any other Sickness for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetricians and Gynecologists, and such coverage must include an in-hospital stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.

Benefits will be provided in all cases of early discharge for post-delivery care within the minimum time periods established above to be delivered in the Insured's home, or, in a Physician's office, as determined by the Physician in consultation with the Insured. The at-home post-delivery care shall be provided by a Physician which includes a registered professional nurse, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

1. Parental education.
2. Assistance and training in breast or bottle feeding.
3. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for colorectal cancer screening for Insured Persons. The screening shall be in compliance with American Cancer Society colorectal cancer screening guidelines, as updated.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CYTOLOGIC SCREENING AND MAMMOGRAPHIC EXAMINATIONS

Benefits will be paid the same as any other Sickness for the following:

1. Annual cervical cytologic screening and cervical cytologic screening for women upon certification by the attending Physician that the test is a Medical Necessity.
2. A baseline mammogram and an annual screening mammogram for women, including 3-D mammogram.
3. Adjuvant breast cancer screening, including magnetic resonance imaging, ultrasound screening, or molecular breast imaging of the breast, if:
   a. A mammogram demonstrates a Class C or Class D Breast Density Classification.
   b. A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk of cancer as determined by a woman's Physician or advanced practice Registered Nurse.

All such services must be in accordance with the standard practice of medicine.

"Breast density classification" means the four levels of breast density identified in the Breast Imaging Reporting and Data System established by the American College of Radiology, which are:

1. Class A, indicating fatty breast tissue.
2. Class B, indicating scattered fibroglandular breast tissue.
3. Class C, indicating heterogeneously dense breast tissue with fibrous and glandular tissue that are evenly distributed throughout the breast.
4. Class D, indicating extremely dense breast tissue.

Benefits shall not be subject to any Coinsurance or Deductible, but shall be subject to all other limitations and provisions of the Policy

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening in accordance to the latest screening guidelines issued by the American Cancer Society.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR VOLUNTARY HIV SCREENING TEST DURING EMERGENCY ROOM VISIT

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits shall include one emergency department HIV screening test; the cost of administering such test, all laboratory expenses to analyze the test; the cost of communicating to the Insured the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services. Benefits shall not be subject to any Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

1. Conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, other suitable rapid-result test.
2. If the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

BENEFITS FOR CHEMOTHERAPY PILLS

Benefits will be provided for prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than coverage provided for intravenously administered or injected cancer medications. In addition, Insured Persons receiving such prescribed medication shall have the option of having it dispensed at any appropriately licensed pharmacy.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs for those health care services, items or drugs for a Qualified Individual participating in an Approved Clinical Trial if the service, item or drug would have been a Covered Medical Expense had it not been administered in a clinical trial.

"Approved clinical trial" means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare and Medicaid Services.
    e. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group,
    f. and the Community Programs for Clinical Research in AIDS.
    g. The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.
2. A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA.
3. An investigational or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Qualified individual" means an Insured who is eligible to participate in an Approved Clinical Trial undertaken for the purposes of prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life threatening illness.

"Routine patient care costs" means:

1. Items, drugs, and services that are typically provided absent a clinical trial.
2. Items, drugs, and services required solely for the provision of the investigational item or service (such as administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.

Routine patient care costs shall not include:

1. The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection or analysis.
2. Items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR TELEHEALTH SERVICES

Benefits will be provided for services delivered through Telehealth on the same basis as services when delivered in person.

"Telehealth" means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of any of the following:

1. Diagnosis.
2. Consultation.

3. Treatment.

Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not considered Telehealth and are not covered services.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR PRESCRIPTION CONTRACEPTIVES

Benefits will be provided for up to a 12 month supply of a prescribed Contraceptive at one time.

Contraceptive means a drug or drug regimen approved by the U.S. Food and Drug Administration to prevent pregnancy.

This benefit does not require additional coverage for Contraceptives that are not covered under the Policy.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, Limitations, or any other provisions of the Policy.

[Section [8]: Excess Provision

[Even if you have other insurance, the plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other [group] insurance.] [Benefits will be paid on the unpaid balances after your other [group] insurance has paid.]

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible [group] insurance [or under an automobile insurance policy].

[However, this Excess Provision will not be applied to the first [$100 - $10,000] of medical expenses incurred.]

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with Policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other [group] insurance does not cover the loss.]

[Section [9]: Coordination of Benefits Provision

Benefits will be coordinated with any other eligible medical, surgical, or hospital Plan or coverage so that combined payments under all programs will not exceed 100% of Allowable Expenses incurred for covered services and supplies.

Definitions

1. **Allowable Expenses:** Any health care expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.
    - The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
    - For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
    - For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
    - If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit

or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admission, and preferred provider arrangements.

2. **Plan:** A form of coverage with which coordination is allowed.

   Plan includes all of the following:
   - Group insurance contracts and subscriber contracts.
   - Uninsured arrangements of group or group-type coverage.
   - Group coverage through closed panel Plans.
   - Group-type contracts, including blanket contracts.
   - The medical care components of long-term care contracts, such as skilled nursing care.
   - The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
   - Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

   Plan does not include any of the following:

   - Hospital indemnity coverage benefits or other fixed indemnity coverage.
   - Accident only coverage.
   - Limited benefit health coverage as defined by state law.
   - Specified disease or specified accident coverage.
   - School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
   - Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
   - Medicare supplement policies.
   - State Plans under Medicaid.
   - A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
   - An Individual Health Insurance Contract.

3. **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.

4. **Secondary Plan:** A Plan that is not the Primary Plan.

5. **We, Us or Our:** The Company named in the Policy.

Rules for Coordination of Benefits - When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are outlined below.

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary. This does not apply to coverage that is

obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Plan to provide out of network benefits.

If the Primary Plan is a closed panel Plan and the Secondary Plan is not a closed panel Plan, the Secondary Plan shall pay or provide benefits as if it were the Primary Plan when an Insured Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Order of Benefit Determination - Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the Plan covering the person as other than a dependent, then the order of benefit is reversed. The Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
   - the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
   - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

3. **Dependent Child/Parents Divorced, Separated or Not Living Together.** If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

   If the specific terms of a court decree state that one of the parents is responsible for the health care services or expenses of the child and that Plan has actual knowledge of those terms, that Plan is Primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's Plan is the Primary Plan. This item shall not apply with respect to any Plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

   If a court decree states that both parents are responsible for the child's health care expenses or coverage, the order of benefit shall be determined in accordance with part (2).

   If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the order of benefits shall be determined in accordance with the rules in part (2).

   If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
   - First, the Plan of the parent with custody of the child.
   - Then the Plan of the spouse of the parent with the custody of the child.
   - The Plan of the parent not having custody of the child.
   - Finally, the Plan of the spouse of the parent not having custody of the child.

4. **Dependent Child/Non-Parental Coverage.** If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.

5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
   - Second, the benefits under the COBRA or continuation coverage.
   - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

If none of the provisions stated above determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.]

[Section [10]: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight
If such Injury shall independently of all other causes and within [90 - 365] days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

[Life	$[500.00 - 25,000.00]
Both Hands, Both Feet, or Sight of Both Eyes	$[500.00 - 25,000.00]
One Hand [and] One Foot	$[500.00 - 25,000.00]
Either One Hand or One Foot and Sight of One Eye	$[500.00 - 25,000.00]
One Hand or One Foot or Sight of One Eye	$[500.00 - 25,000.00]
[Entire Thumb and Index Finger of Either Hand	$[500.00 - 25,000.00]]

Loss shall mean with regard to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.]

[Life	$[500.00 - 25,000.00]
Two or More Members	$[500.00 - 25,000.00]
One Member	$[500.00 - 25,000.00]
[Thumb or Index Finger	$[500.00 - 25,000.00]]

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.]]

[Section [10]: [Accidental] Death Benefit

If an accidental Injury should independently of all other causes [and within [90 - 365] days from the date of Injury solely] result in the loss of the Insured's life, [or if a covered Sickness should result in the loss of the Insured's life,] the Insured's beneficiary may request the Company to pay $[500 – 25,000] in addition to payment under any Medical Expense Benefit provision.]

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required

[STUDENTS ONLY]
[OUTPATIENT SERVICES ONLY]
The student [and Spouse[/Dependents]] [must] [should] use the services of the [Health Center] first where [outpatient] treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the [Student Health Center] for which no prior approval or referral is obtained [are excluded from coverage] [will be subject to [an additional] [a] [$25 - 500] Deductible] [will be paid at [50 - 90%] of the benefits otherwise payable under the Schedule of Benefits]. A referral issued by the [SHC] must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A [SHC] referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. [The student must return to [SHC] for necessary follow-up care].
[2. When the [Student Health Center] is closed.]
[3. When service is rendered at another facility during break or vacation periods.]
[4. Medical care received when the student is more than [10-50 miles] from campus.]
[5. Medical care obtained when a student is no longer able to use the [SHC] due to a change in student status.]
[6.] Maternity, obstetrical and gynecological care.
[7. [Mental Illness treatment] [and] [Substance Use Disorder treatment].]

[[Dependents] [Dependent children] are not eligible to use the [SHC] and therefore are exempt from the above limitations and requirements.]]

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required

[PHYSICIAN'S VISITS]
Insurance benefits for [Physician's visits] are provided only upon referral by the [Student Health Center]. Expenses incurred for [Physician's visits] for which no prior approval or referral is obtained [are excluded from coverage] [will be subject to [an additional] [a] [$25 – 500] Deductible] [will be paid at [50 - 90%] of the benefits otherwise payable under the Schedule of Benefits]. A referral issued by the [SHC] must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A [SHC] referral is not necessary only under any of the following conditions:

1. Medical Emergency. [The student must return to [SHC] for necessary follow-up care].
[2. When the [Student Health Center] is closed.]
[3. When service is rendered at another facility during break or vacation periods.]
[4. Medical care received when the student is more than [10-50 miles] from campus.]
[5. Medical care obtained when a student is no longer able to use the [SHC] due to a change in student status.]

[6.] Maternity, obstetrical and gynecological care.
[7. [Mental Illness treatment] [and] [Substance Use Disorder treatment].]

[[Dependents] [Dependent children] are not eligible to use the [SHC] and therefore are exempt from the above limitations and requirements.]]

[Section [11]: [Student Health Center (SHC)] [University Health Service (UHS)] Referral Required

[STUDENTS ONLY]
The student [and Spouse[/Dependents]] should use the services of the [Health Center] first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the [Student Health Center] for which no prior approval or referral is obtained will be paid at the Out-of-Network level of benefits as specified in the Schedule of Benefits. A referral issued by the [SHC] must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A [SHC] referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. [The student must return to [SHC] for necessary follow-up care].
[2. When the [Student Health Center] is closed.]
[3. When service is rendered at another facility during break or vacation periods.]
[4. Medical care received when the student is more than [50 miles] from campus.]
[5. Medical care obtained when a student is no longer able to use the [SHC] due to a change in student status.]
[6.] Maternity, obstetrical and gynecological care.
[7. [Mental Illness treatment] [and] [Substance Use Disorder treatment].]

[Dependents [Dependent children] are not eligible to use the [SHC]; and therefore, are exempt from the above limitations and requirements.]]

[Section [12]: Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least [3 - 12] [consecutive months] [one semester] [or] [one quarter] and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than [[30 - 90] days] [[3 – 6] months] under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

[Application must be made and] [P][p]remium must be paid directly to [UnitedHealthcare **Student**Resources] and be received within [14 - 31] days after the expiration date of the Insured's coverage. For further information on the Continuation Privilege, please contact [UnitedHealthcare **Student**Resources].]]

[Section [13]: Dental Benefits

Benefits will be paid for the following specific procedures. Payment will not exceed [the maximum amount specified for each procedure].

[Insert E]

[E] = any dental procedure listed in the "Code for Most Frequently Repeated Dental Procedures" published by the Journal of the American Dental Association.]

[Section [14]: [Student Health Center] - [Routine Foot Care Treatment] (Any service or treatment listed in the Exclusions and Limitations section)

Benefits will be paid for [routine foot care including the care, cutting, and removal of [corns,] [calluses,] [toenails,] and [bunions]] provided that [[the surgery is performed] [the treatment is rendered] at [the Student Health Center]] [or] [the Insured obtains a referral from the Student Health Center for outside treatment]. [The referral issued by the Student Health Center must accompany the claim when submitted.]]

Section [15]: Definitions

ADOPTED [OR FOSTER] CHILD means the adopted child [or foster child] placed with an Insured while that person is covered under the Policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted [or foster] child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

[Benefits will also be provided for another child placed in court-ordered temporary or other custody of the Insured from the moment of placement.]

[The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.]

CIVIL UNION means a same-sex relationship similar like marriage that is recognized by law.

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the Policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the Policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to the Policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

DEPENDENT means the legal spouse (regardless of gender), Civil Union partner, the Named Insured's partner in a recognized, legal marriage entered into in another jurisdiction that is not expressly prohibited or deemed illegal in the District of Columbia [or the Named Insured's Domestic Partner] and their dependent children by blood or by law, including Civil Union partner's children. Children shall cease to be dependent at the end of the month in which they attain the age of [26 – 30] years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
2. Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the Policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

DOMESTIC PARTNER means either: 1) a person who has registered in a state or local domestic partner registry with an Insured Person or 2) each of two people, one of whom is a Named Insured, who has submitted an affidavit to the Policyholder certifying that: (a) each person is 18 years of age; (b) neither person has another domestic partner (or another spouse); and (c) both persons live together in the same residence and intend to do so indefinitely which may be demonstrated by providing valid documentation, such as a joint mortgage or lease, or joint financial statements.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.

Habilitative services do not include Elective Surgery or Elective Treatment or services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis [and major surgery] on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home. Hospital also means a licensed alcohol and drug abuse rehabilitation facility and a mental hospital. Alcohol rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises or on a prearranged basis.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is all of the following:

1. Directly and independently caused by specific accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician within [30 - 365] days after the date of accident.
5. Sustained while the Insured Person is covered under the Policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under the Policy.

INPATIENT REHABILITATION FACILITY means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

INSURED PERSON means: [1)] the Named Insured[; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the Policy, and 2) the appropriate Dependent premium has been paid]. The term Insured also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1. Progressive care.
2. Sub-acute intensive care.
3. Intermediate care units.
4. Private monitored rooms.
5. Observation units.
6. Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1. Death.
2. Placement of the Insured's health in jeopardy.
3. Serious impairment of bodily functions.
4. Serious dysfunction of any body organ or part.
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1. Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2. Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.
3. In accordance with the standards of good medical practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both:

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

The Policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement. The fact that a Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by this policy.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases* does not mean that treatment of the disorder is a Covered Medical Expense. [If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.]

NAMED INSURED means an eligible, [registered student] [participant] of the Policyholder, if: 1) the [student] [participant] is properly enrolled in the Policy; and 2) the appropriate premium for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

[The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.]

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person’s immediate family.

The term “member of the immediate family” means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

POLICY OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

POLICY YEAR means the period of time beginning on the Policy Effective Date and ending on the Policy Termination Date.

POLICYHOLDER means the institution of higher education to whom the Master Policy is issued.

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under the Policy. [All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness.] [Covered Medical Expenses incurred as a result of an Injury that occurred prior to the Policy’s Effective Date will be considered a sickness under the Policy.]

SKILLED NURSING FACILITY means a Hospital or nursing facility that is licensed and operated as required by law.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or *International Classification of Diseases* does not mean that treatment of the disorder is a Covered Medical Expense. [If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.]

URGENT CARE CENTER means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

USUAL AND CUSTOMARY CHARGES means the maximum amount the Policy is obligated to pay for services. Except as otherwise required under state or federal regulations, usual and customary charges will be the lowest of:

1. The billed charge for the services.
2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered.
3. An amount determined using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical difference where applicable, plus a margin factor.

The Company uses data from [FAIR Health, Inc.] [and/or] [Data iSight] to determine Usual and Customary Charges. [Usual and Customary Charges determined using data from FAIR Health, Inc. will be calculated at the [75th – 90th] percentile.] No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Section [16]: Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. [Acne[, except as specifically provided in the Policy].]
2. [Acupuncture, except as specifically provided in the Policy.]
3. [Addiction, such as:
   - [Caffeine addiction.]
   - [Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.]
   - [Codependency.]]
4. [[Conceptual handicap.] [Developmental delay or disorder or mental retardation.] [Learning disabilities.] [Milieu therapy.] [Parent-child problems.]
   [This exclusion does not apply to benefits specifically provided in the Policy.]]
5. [Biofeedback[, except as specifically provided in the Policy].]
6. [Chronic pain disorders.]
7. [Circumcision.]
8. [Cosmetic procedures, except [as specifically provided in the Policy or] reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.]
9. [Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, [college infirmaries] or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.]
10. Dental treatment, except:
    - For accidental Injury to [Sound,] Natural Teeth.
    - For treatment of cleft lip and cleft palate.
    - [As specifically provided in the Schedule of Benefits.]

    This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
11. [Elective Surgery or Elective Treatment.]
12. [Elective abortion.]
13. [Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline[, or chartered aircraft only while participating in a school sponsored [intercollegiate sport][activity]].]
14. [Foot care for the following[, except as specifically provided in the Policy]:
    - [Flat foot conditions.]
    - [Supportive devices for the foot.]

- [Subluxations of the foot.]
- [Fallen arches.]
- [Weak feet.]
- [Chronic foot strain.]
- [Routine foot care including the care, cutting and removal of [corns,] [calluses,] [toenails,] [and] [bunions (except capsular or bone surgery)].]

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.]

15. [Health spa or similar facilities.] [Strengthening programs.]
16. [[Hearing examinations.] [Hearing aids.] Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - [Benefits specifically provided in the Policy.]
    - Hearing screenings specifically provided for in Benefits for Child Health Screening Services.]
17. [Hirsutism.] [Alopecia.]
18. [Hypnosis.]
19. [Immunizations, except as specifically provided in the Policy.] [Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.]
20. [Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.]
21. [Injury or Sickness outside the United States and its possessions[, Canada] [or] [Mexico][, except [for a Medical Emergency] when traveling for [academic study abroad programs,] [business] [or] [pleasure]].]
22. [Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance [in excess of $[500 – 20,000]].]
23. [Injury sustained while:
    - Participating in any [intercollegiate] [or] [professional] sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.]
24. [Injury sustained while:
    - Participating in any contest or competition of intercollegiate [football, etc.].
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.]
25. [Investigational services.]
26. [Lipectomy.]
27. [[Marital] [or] [family] counseling.]
28. [Motor vehicle Injury.]
29. [Nuclear, chemical or biological Contamination, whether direct or indirect. “Contamination” means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death.]
30. [Outpatient Physiotherapy; except when referred by the Student Health Center or as specifically provided in Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects.]
31. [Participation in a riot or civil disorder. Commission of or attempt to commit a felony. [Fighting.]]
32. [Prescription Drugs, services or supplies as follows[, except as specifically provided in the Policy]:
    - [Therapeutic devices or appliances, including: [hypodermic needles,] [syringes,] support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.]
    - [Immunization agents, except as specifically provided in the Policy.]
    - [Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, except as specifically provided in the Policy.]
    - [Products used for cosmetic purposes.]
    - [Drugs used to treat or cure baldness.] [Anabolic steroids used for body building.]
    - [Anorectics - drugs used for the purpose of weight control.]
    - [Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.]
    - [Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.]]
33. [Reproductive~~/Infertility~~ services ~~including but not limited to~~for the following[, except as specifically provided in the Policy]:
    - [Procreative counseling.]
    - [Genetic counseling] [and] [genetic testing].~~]~~
    - [Cryopreservation of reproductive materials.] [Storage of reproductive materials.]
    - [Fertility tests, except to diagnose the underlying cause of infertility including testing and counseling.]

- [Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.]
- [Premarital examinations.]
- [Impotence, organic or otherwise.]
- [Female sterilization procedures, except as specifically provided in the Policy.]
- [Vasectomy.]
- [Reversal of sterilization procedures.]]

34. [Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except for Covered Medical Expenses incurred in connection with participation in approved clinical trials.]
35. [[Routine eye examinations.] [Eye refractions.] [Eyeglasses.] [Contact lenses.] [Prescriptions or fitting of eyeglasses or contact lenses.] [Vision correction surgery.] [Treatment for visual defects and problems.]
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - [To benefits specifically provided in the Policy.]]
36. [Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.]
37. [Preventive care services which are not specifically provided in the Policy, including:
    - [Routine physical examinations and routine testing.]
    - [Preventive testing or treatment.]
    - [Screening exams or testing in the absence of Injury or Sickness.]]
38. [Services provided [normally without charge] by the Health Service of the Policyholder.] [Services covered or provided by the student health fee.]
39. [[Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia.] [Temporomandibular joint dysfunction, except for surgical treatment.] [Deviated nasal septum, including submucous resection and/or other surgical correction thereof.] [Nasal and sinus surgery, except for treatment of a covered Injury[or treatment of chronic sinusitis].] [This exclusion does not apply to benefits specifically provided in the Policy.]]
40. [Skiing.] [Snowboarding.] [Scuba diving.] [Surfing.] [Roller skating.] [Skateboarding.] [Riding in a rodeo.]
41. [Skydiving.] [Parachuting.] [Hang gliding.] [Glider flying.] [Parasailing.] [Sail planing.] [Bungee jumping.]
42. [Sleep disorders[, except as specifically provided in the Policy].]
43. [Speech therapy, except as specifically provided in the Policy.] [Naturopathic services.]
44. [Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.]
45. [Supplies, except as specifically provided in the Policy.]
46. [Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, [or gynecomastia,] except as specifically provided in the Policy.]
47. [Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
    - [Motorcycle.]
    - [Recreational vehicle including but not limiting to: [two- or three-wheeled motor vehicle,] [four-wheeled all terrain vehicle (ATV),] [jet ski,] [ski cycle,] [or] [snowmobile].]]
48. [Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.]
49. [War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).]
50. [[Weight management.] [Weight reduction.] [Nutrition programs.] [Treatment for obesity [(except [surgery for] morbid obesity)].] [Surgery for removal of excess skin or fat.] This exclusion does not apply to benefits specifically provided in the Policy.]

Section [17]: How to File a Claim for Injury and Sickness Benefits

[In the event of Injury or Sickness, students should:]

1. [Report [to the [Student Health Service] [or] [Infirmary] [for [treatment] [or] [referral]], or when not in school,] to their Physician or Hospital.]
2. [Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the [college] [or] [university] under which the student is insured.] [A Company claim form is not required for filing a claim.]

3. [Secure a Company claim form [from the Student Health Service] [or] [from the address below], [fill in the necessary information,] [have the attending physician complete his portion of the form,] [fill out the form completely,] attach all medical and hospital bills and mail to the address below.] [No claim will be paid unless a Company claim form is filled out completely and mailed to the address below.]
4. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

[UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
~~[By facsimile (fax):~~
[xxx-xxx-xxxx]]

Section [18]: General Provisions

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, [P.O. Box 809025, Dallas, Texas 75380-9025] with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: [Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.] [Claim forms are not required.]

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION AND AUTOPSY: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

Section [19]: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at [800-767-0700] with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: [UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025].

Internal Appeal Process
Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination.

Upon receipt of the request for an Internal Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within 10 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the grievance; and
2. Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 business days to respond to any new or additional evidence or rationale.

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company's receipt of the grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
   f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Review (EIR).

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact [Claims Appeals] at [888-315-0447]. The written request for an Expedited Internal Appeal should be sent to: [Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025].

Expedited Internal Review Process

The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

1. Involving Urgent Care Requests; and
2. Related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized

Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance

Office of the Health Care Ombudsman and Bill of Rights
441 4th Street, NW, Suite ~~900~~ 250N ~~South~~
Washington, D.C. 20001
Phone: (202) 724-7491
Toll Free: (877) 685-6391
Fax: (202) 442-6724
Email: healthcareombudsman@dc.gov
Website: healthcareombudsman.dc.gov

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases:

Commissioner
Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor
Washington, D.C. 20002
Phone: (202) 727-8000
Fax: (202) 354-1085

RIGHT TO EXTERNAL INDEPENDENT REVIEW

After exhausting the Company's Internal Appeal process, an Insured Person or Authorized Representative may submit a request for an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, or the treatment is determined to be experimental or investigational.

A request for an External Independent Review shall not be made until the Insured Person or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Process shall be considered exhausted if:

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Director. Upon request of an External Review, the Director shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests
All types of External Review requests shall be submitted to the state insurance department at the following address:

Grievance and Appeals Coordinator
Office of the General Counselor
District of Columbia Department of Health
825 North Capital Street, N.E., Room 4119
Washington, D.C. 20002
Phone: 202-442-5979
Fax: 202-442-4797

Standard External Review (SER) Process
A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. Within 5 business days after receiving the SER request notice, the Director will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. After completion of the preliminary review, the Director shall notify the Company, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Director's response shall include what information or materials are needed to make the request complete;
3. If the request is not eligible, the Director's response shall include the reasons for ineligibility. After receiving notice that a request is eligible for SER, the Director shall, within 1 business day:
   a. Assign an Independent Review Organization (IRO) from the Director's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4. a. The Company shall, within 7 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses it decision, the Company shall provide written notification within 1 business day to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 30 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Director. The

Director will forward copies of the recommendation to the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Director at the time the Insured Person receives:
   a. An Adverse Determination if:
      - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      - The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

   b. A Final Adverse Determination, if:
      - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
      - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

2. Upon receipt of an EER request, the Director shall immediately send a copy of the request to the Company.
3. Upon receipt of a request for an EER, the Director shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
4. Immediately after completion of the review, the Director shall notify the Company, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
   a. If the request is not complete, the Director's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Director's response shall include the reasons for ineligibility.
5. When a request is complete and eligible for an EER, the Director shall immediately assign an Independent Review Organization (IRO) from the Director's approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
   b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall, make a recommendation to the Director to uphold or reverse the Adverse Determination or Final Adverse Determination.
8. After receipt of the recommendation, the Director shall notify the Company, the Insured Person, and, if applicable, the Authorized Representative.
9. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Company except to the extent the Company has other remedies available under state law. An External Review decision is binding on the Insured Person to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or an Authorized Representative may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Insured Person has already received an External Review decision.

APPEAL RIGHTS DEFINITIONS
For the purpose of this Notice of Appeal Rights, the following terms are defined as shown below:

Adverse Determination means:
1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

Authorized Representative means:
1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Director means the Director, District of Columbia Department of Health.

Evidenced–based Standard means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Final Adverse Determination means an Adverse Determination involving a Covered Medical Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Prospective Review means Utilization Review performed: 1) prior to an admission or the provision of a health care service or course of treatment; and 2) in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

Retrospective Review means any review of a request for a Covered Medical Expense that is not a Prospective Review request. Retrospective review does not include the review of a claim that is limited to the veracity of documentation or accuracy of coding.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

Questions Regarding Appeal Rights
Contact Customer Service at [1-800-767-0700] with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

DC Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th Street, NW, ~~900~~ Suite 250N ~~South~~
Washington, D.C. 20001
Phone: (202) 724-7491
Fax: (202) 442-6724

[Section [20]: Online Access to Account Information

[UnitedHealthcare **Student**Resources] Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to **My Account** at [www.uhcsr.com/myaccount]. Insured students who don't already have an online account may simply select the "~~c~~Create Account~~***My Account*** Now~~" link. Follow the simple, onscreen directions to establish an online account in minutes using the Insured's 7-digit Insurance ID number or the email address on file.

As part of [UnitedHealthcare **Student**Resources'] environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes a ~~M~~message ~~C~~center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. ~~In *Message* Center, n~~Notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into ~~My Email Preferences~~My Profile and making the change there.]

[Section [21]: ID Cards

Digital ID cards will be made available to each Insured Person. The Company will send an email notification when the digital ID card is available to be downloaded from **My Account**. An Insured Person may also use **My Account** to request delivery of a permanent ID card through the mail.]

[Section [22]: UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or ~~Apple's~~ the App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. [Covered Dependents are also included.]
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider's office or facility, and locate the provider's office or facility on a map.
- Find My Claims – view claims received within the past 120 days for [both] the primary Insured [and covered Dependents]; includes provider, date of service, status, claim amount and amount paid.]

Section [23]: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

[Administrative Office:
[UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700]
Web site: [www.uhcsr.com]]

[Serviced by:
ABC Agency
123 Avenue
Anytown, USA
1-888-888-8888

Web site: [www.uhcsr.com]]

[Sales/Marketing Services:
[UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
E-mail: info@uhcsr.com]

[Customer Service:
[800-767-0700]
(Customer Services Representatives are available [Monday - Friday, [7:00 a.m. – 7:00 p.m.] (Central Time)])]

Schedule of Benefits

[Policyholder Name]

[Policy Number]

{[Plan I] [Plan II]

METALLIC LEVEL – [BRONZE] [SILVER] [GOLD] [PLATINUM] WITH ACTUARIAL VALUE OF [60 – 99]%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible [Preferred Provider]	$[0 - Highest amount allowed under the Affordable Care Act] [(Per Insured Person, Per Policy Year)] [(For each Injury or Sickness)] [The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]
[Deductible [Preferred Provider]	$[0 - Highest amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]
[Deductible [Out-of-Network]	$[0 - 15,000] [(Per Insured Person, Per Policy Year)] [(For each Injury or Sickness)]] [The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]
[Deductible [Out-of-Network]	$[0 - 45,000] (For all Insureds in a Family, Per Policy Year)]
Coinsurance [Preferred Provider]	[[50 – 100]%] [[50 - 100]% to $[1,000 – 50,000], then [50 - 100%] thereafter] [[50 – 100] % to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter]
Coinsurance [Out-of-Network]	[[50 – 100]%] [[50 - 100]% to $[1,000 – 50,000], then [50 – 100]% thereafter] [[50 – 100]% to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter]
Out-of-Pocket Maximum [Preferred Provider]	$[0 - Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (Per Insured Person, Per Policy Year)
[Out-of-Pocket Maximum [Preferred Provider]	$[0 - Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]
[Out-of-Pocket Maximum [Out-of-Network]	$[0 - 45,000] (Per Insured Person, Per Policy Year)]
[Out-of-Pocket Maximum [Out-of-Network]	$[0 - 45,000] (For all Insureds in a Family, Per Policy Year)]

[The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers [and [50% - 100]% for Out-of-Network Providers] up to $[1,000 - 50,000]. After the Company has paid $[1,000 – 50,000], benefits will be paid for additional Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers [and [50 – 100]% for Out-of-Network Providers].]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers up to $[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the $[500 – Highest amount allowed under the Affordable Care Act] [Preferred Provider] Deductible [and $[500 – 10,000] Out-of-Network Deductible]. After the Company pays $[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 - 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers.]

The [In-Network] [Preferred Provider] for this plan is [University Hospital] [UnitedHealthcare Options PPO].

If care is received [within the Network] [from a Preferred Provider] any Covered Medical Expenses will be paid at the [In-Network] [Preferred Provider] level of benefits. [If [an In-Network] [a Preferred] Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as [In-Network] [Preferred Provider] benefits.] If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the [In-Network] [Preferred Provider] level of benefits. [Covered Medical Expenses incurred at [a Preferred Provider] [an In-Network] facility by an Out-of-Network Provider will be paid at the [Preferred Provider] [In-Network] level of benefits.] [Except for a Medical Emergency, Covered Medical Expenses incurred at [a Preferred Provider] [an In-Network] facility by an Out-of-Network provider will be paid at the Out-of-Network level of benefits.] [In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.]

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year[subject to any benefit maximums or limits that may apply]. [Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits.] [Covered Medical Expenses used to satisfy the Out-of-Pocket Maximum will be applied to both the Preferred Provider and Out-of-Network Out-of-Pocket Maximum.] Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses [and the amount benefits are reduced for failing to comply with Policy provisions or requirements] do not count toward meeting the Out-of-Pocket Maximum. [Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays].

[Student Health Center Benefits: [The [Deductible] [and] [Copays] will be waived] [and] [benefits will be paid at [100%] [for Covered Medical Expenses incurred] [of billed charges] [of the [Preferred Provider] [In-Network] level of benefits] when treatment is rendered at [or referred by] the Student Health Center] [for the following services: [e.g., any services listed in the schedule of benefits].] [Policy Exclusions and Limitations do not apply.]]

[**Out-of-Country Claims:** Covered Medical Expenses incurred outside the United States will be paid at [the [Preferred] [In-Network] Provider level of benefits] [[50 – 100]% [Coinsurance] [of Usual and Customary Charges]] [the Out-of-Network level of benefits] [and the Deductible will be waived].]
~~**[Copays:** All [Preferred Provider][,] [In-Network][,] [and] [Out-of-Network] Copays specified in the Schedule of Benefits are in addition to the Policy Deductible[, except for Prescription Drugs].]~~

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below [All benefit maximums are combined [Preferred Provider] [In-Network] and [Out-of-Network] unless otherwise specifically stated.] Please refer to the Medical Expense Benefits – Injury and Sickness section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Room and Board Expense	[$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Intensive Care	[$[100 – 1,000] Copay per day [to a maximum Copay of [$100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 1,000] Copay per day [to a maximum Copay of [$100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Hospital Miscellaneous Expenses	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Inpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Routine Newborn Care See Benefits for Postpartum Care	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Anesthetist Services	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 – 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 – 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Registered Nurse's Services [[10 – 365] days maximum [per Policy Year] [for each Injury or Sickness]]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [No Benefits]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [No Benefits]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [No Benefits]
Physician's Visits	[$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Pre-admission Testing [Payable within [7 – 14] working days prior to admission.]	[Paid under Hospital Miscellaneous Expenses] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[Paid under Hospital Miscellaneous Expenses] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[Paid under Hospital Miscellaneous Expenses] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Day Surgery Miscellaneous	[$[10 – 1,000] Copay [per date of service]] [[50-100]% of] [Preferred	[$[10 – 1,000] Copay [per date of service]] [[50-100]% of] [Preferred	[$[10 - 1,000] Copay [per date of service]]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
	Allowance] [after Deductible][not subject to Deductible]	Allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Anesthetist Services	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [after Deductible][not subject to Deductible]
Physician's Visits	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Physiotherapy [Preferred Provider] [Out-of-Network] [Limits [per Policy Year] [for each Injury or Sickness] as follows: [90 – 160] visits of cardiac rehabilitation therapy] [Benefits are payable only when referred by the [Student Health Center].] [Review of Medical Necessity will be performed after [12 – 24] visits per Injury or Sickness.] See also Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Medical Emergency Expenses [The [Preferred Provider][,] [In-Network][,] [and] [Out-of-Network] Copay will be waived if admitted to the Hospital.]	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 500] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Diagnostic X-ray Services	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Radiation Therapy	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not	[$[5 - 100] Copay [per treatment] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
	subject to Deductible]	subject to Deductible]	subject to Deductible]
Laboratory Procedures	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Tests & Procedures	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 500] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Injections	[$[5 – 50] Copay [per injection] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 50] Copay [per injection] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 50] Copay [per injection] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Chemotherapy	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per treatment] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 - 100] Copay [per treatment] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Prescription Drugs [The Policy does not include a pharmacy network for Prescription Drugs. All Prescription Drug benefits are payable under the Out-of-Network Provider benefits.] [*See UHCP Prescription Drug Benefit Endorsement for additional information.]	[Not Available] [*[UnitedHealthcare Pharmacy [(UHCP),]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [[$[0-75] Copay per prescription [Tier 1]] [$[0 - 250] Copay per prescription [Tier 2]] [$[0 - 450] Copay per prescription [Tier 3]] [$[0 - 650] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge][up to a [30 - 31]-day supply per prescription] [not subject to Deductible] [When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail [Copay] [and/or] [Coinsurance] (up	[Not Available] [*[UnitedHealthcare Pharmacy [(UHCP),]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [[$[0-75] Copay per prescription [Tier 1]] [$[0 - 250] Copay per prescription [Tier 2]] [$[0 - 450] Copay per prescription [Tier 3]] [$[0 - 650] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge][up to a [30 - 31]-day supply per prescription] [not subject to Deductible] [When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail [Copay] [and/or] [Coinsurance] (up	[$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [$[0-450] Copay per prescription [generic drug]] [$[0 – 450] Copay per prescription brand-name drug] [[50-100]% of] [Usual and Customary Charges [generic drug]] [[50-100]% of] [Usual and Customary Charges brand-name drug] [in addition to the Policy Deductible] [up to a [30 - 31]-day supply per prescription] [after Deductible][not subject to Deductible] [No Benefits]

Outpatient	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
	to 50% of the Prescription Drug Charge).] [Mail order Prescription Drugs [through [UHCP]] [at [2 - 2.5] times the retail Copay[up to a 90-day supply]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [[$[0 - 225] Copay per prescription [Tier 1]] [$[0 - 750] Copay per prescription [Tier 2]] [$[0 – 1,350] Copay per prescription [Tier 3]] [$[0 - 1,950] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge] [up to a 90-day supply] [not subject to Deductible]]]	to 50% of the Prescription Drug Charge).] [Mail order Prescription Drugs [through [UHCP]] [at [2 - 2.5] times the retail Copay[up to a 90-day supply]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [[$[0 - 225] Copay per prescription [Tier 1]] [$[0 - 750] Copay per prescription [Tier 2]] [$[0 – 1,350] Copay per prescription [Tier 3]] [$[0 - 1,950] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge] [up to a 90-day supply] [not subject to Deductible]]]	

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Ambulance Services	[$[25 – 1,000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 1,000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[25 – 1,000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Durable Medical Equipment	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Consultant Physician Fees	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and treatment of cleft lip and cleft palate only.	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness]	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness]	[$[5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness]
[Dental Treatment Benefits paid for removal of impacted wisdom teeth only. [$[50 – 1,500] maximum per procedure]	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Mental Illness Treatment	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] ~~Paid as any other Sickness~~	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] ~~Paid as any other Sickness~~	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]~~Paid as any other Sickness~~

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Substance Use Disorder Treatment	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] ~~Paid as any other Sickness~~	**Inpatient:** [$[100 – 1,000] Copay per day [to a maximum Copay of $[100 – 5,000] per Hospital Confinement]] [$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: [$[5 – 100] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] ~~Paid as any other Sickness~~	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]~~Paid as any other Sickness~~
Maternity See Benefits for Postpartum Care	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
[Elective Abortion [$[100 – 1,000] maximum] [per Policy Year]	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]]
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit [https://www.healthcare.gov/preventive-care-benefits/] for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	[$[5 – 100] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per visit] [per service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [No Benefits]
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
[High Cost Procedures	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Home Health Care [[90 – 200] visits maximum per Policy Year]	[$[5 – 50] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 50] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 50] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Hospice Care [[180 - 220] days maximum per Policy Year]	[$[5 – 100] Copay [per day]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per day]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 100] Copay [per day]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Inpatient Rehabilitation Facility [[90 – 180] days maximum per Policy Year]]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Skilled Nursing Facility [[60 – 180] days maximum per Policy Year]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Urgent Care Center	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Hospital Outpatient Facility or Clinic	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Approved Clinical Trials See also Benefits for Clinical Trials	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness	[Paid as any other Sickness] [No Benefits]
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Acupuncture in Lieu of Anesthesia	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness

Other	[Preferred Provider]	[In-Network Provider]	Out-of-Network Provider
Medical Foods	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Medical Supplies Benefits are limited to a 31 day supply per purchase.	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Ostomy Supplies	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Wigs	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible]	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Insert any service excluded under the Policy (e.g. Acne,) [[10 – 100] [days][visits] maximum [per Policy Year] [for each Injury or Sickness]]	~~[Paid as any other Sickness]~~ [$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	~~[Paid as any other Sickness]~~ [$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	~~[Paid as any other Sickness]~~ [$[5 – 2000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]
[Insert any non-essential service excluded under the Policy (e.g. hearing aids, obesity) [[10 – 100] [days] [visits] maximum] [[$[50 – 10,000] maximum] [per Policy Year][for each Injury or Sickness]	~~[Paid as any other Sickness]~~ [$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	~~[Paid as any other Sickness]~~ [$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Preferred Allowance] [after Deductible][not subject to Deductible] [Paid as any other Sickness]	~~[Paid as any other Sickness]~~ [$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]

Schedule of Benefits

[Policyholder Name]

[Policy Number]

[[Plan 1] [Plan II]]

METALLIC LEVEL – [BRONZE] [SILVER] [GOLD] [PLATINUM] WITH ACTUARIAL VALUE OF [60 – 99]%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible	$[0 - Highest amount allowed under the Affordable Care Act] [(Per Insured Person, Per Policy Year)] [(For each Injury or Sickness)] [The Deductible will not be applied until the Company has paid $[1,000 – 25,000] in Covered Medical Expenses.]
[**Deductible**	$[0 - Highest amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]
Coinsurance	**[**[50 – 100]%] [[50 - 100]% to $[1,000 – 50,000], then [50 - 100%] thereafter] [[50 – 100] % to $[1,000 – 25,000], Deductible applies after $[1,000 – 25,000], then [50 – 100]% thereafter]
Out-of-Pocket Maximum	$[0 – Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (Per Insured Person, Per Policy Year)
[**Out-of-Pocket Maximum**	$[0 – Highest Out-of-Pocket Maximum amount allowed under the Affordable Care Act] (For all Insureds in a Family, Per Policy Year)]

[The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% up to $[1,000 - 50,000]. After the Company has paid $[1,000 – 50,000], benefits will be paid for additional Covered Medical Expenses incurred at [50 – 100]%.]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% up to $[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the $[500 – Highest amount allowed under the Affordable Care Act] Deductible. After the Company pays $[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 - 100]%.]

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year [subject to any benefit maximums or limits that may apply]. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses [and the amount benefits are reduced for failing to comply with Policy provisions or requirements] do not count toward meeting the Out-of-Pocket Maximum.

[Student Health Center Benefits: [The [Deductible] [and] [Copays] will be waived] [and] [benefits will be paid at [100%] [for Covered Medical Expenses incurred] [of billed charges] when treatment is rendered at [or referred by] the Student Health Center] [for the following services: [e.g., any services listed in the schedule of benefits].] [Policy Exclusions and Limitations do not apply.]]

[**Out-of-Country Claims**: Covered Medical Expenses incurred outside the United States will be paid at [50 – 100]% [of] [Usual and Customary Charges] [Coinsurance] [and the Deductible will be waived].] ~~**[Copays:** All Copays specified in the Schedule of Benefits are in addition to the Policy Deductible[, except for Prescription Drugs].]~~

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. Please refer to the Medical Expense Benefits – Injury and Sickness section in the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	
Room and Board Expense	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Intensive Care	[$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [Paid under Room & Board] [after Deductible][not subject to Deductible]]
Hospital Miscellaneous Expenses	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Routine Newborn Care See Benefits for Postpartum Care	Paid as any other Sickness
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 1000]% of all subsequent procedures.]	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Anesthetist Services	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Registered Nurse's Services [[10 – 365] days maximum [per Policy Year] [for each Injury or Sickness]]	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [No Benefits]
Physician's Visits	[$[25 – 250] Copay [per visit] [per service]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Pre-admission Testing [Payable within [7 – 14] working days prior to admission.]	[[50 – 100]% of] [Usual and Customary Charges] [Paid under Hospital Miscellaneous Expenses] [after Deductible][not subject to Deductible]

Outpatient	
Surgery [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]	[[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Day Surgery Miscellaneous	[$[10 – 1,000] Copay [per date of service]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Assistant Surgeon Fees	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Anesthetist Services	[[25 – 50]% of surgery allowance] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Outpatient	
Physician's Visits	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Physiotherapy [Limits [per Policy Year] [for each Injury or Sickness] as follows: -[90 – 160] visits of cardiac rehabilitation therapy] [Benefits are payable only when referred by the [Student Health Center].] [Review of Medical Necessity will be performed after [12 – 24] visits per Injury or Sickness.]	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] (See also Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects)
Medical Emergency Expenses [The Copay will be waived if admitted to the Hospital.]	[$[5 – 500] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Diagnostic X-ray Services	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Radiation Therapy	[$[5 – 100] Copay [per treatment] [per visit]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Laboratory Procedures	[$[5 – 100] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Tests & Procedures	[$[5 – 500] Copay per visit] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Injections	[$[5 – 50] Copay [per injection] [per visit]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Chemotherapy	[$[5 – 50] Copay [per treatment] [per visit]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Prescription Drugs [*See UHCP Prescription Drug Benefit Endorsement for additional information.]	[[$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [$[0 - 450] Copay per prescription [generic drug]] [$[0 – 450] Copay per prescription brand-name drug] [[50-100]% of] [Usual and Customary Charges [generic drug]] [[50-100]% of] [Usual and Customary Charges brand-name drug] [in addition to the Policy Deductible] [up to a [30 - 31]-day supply per prescription]] [after Deductible][not subject to Deductible]] [*[UnitedHealthcare Pharmacy [(UHCP),]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) [does not apply to Policy Deductible]] [[$[0-75] Copay per prescription [Tier 1]]

Outpatient	
	[$[0-250] Copay per prescription [Tier 2]] [$[0-450] Copay per prescription [Tier 3]] [$[0-650] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] ~~[in addition to the Policy Deductible]~~ [plus any Ancillary Charge] [up to a [30 - 31]-day supply per prescription] [not subject to Deductible] [When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail [Copay] [and/or] [Coinsurance] (up to 50% of the Prescription Drug Charge).] [Mail order Prescription Drugs [through [UHCP]] [at [2 - 2.5] times the retail Copay[up to a 90-day supply]] [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) ~~[~~does not apply to Policy Deductible~~]~~] [$[0 – 225] Copay per prescription [Tier 1]] [$[0 – 750] Copay per prescription [Tier 2]] [$[0 – 1,350] Copay per prescription [Tier 3]] [$[0 – 1,950] Copay per prescription [Tier 4]] [[50 -100]% Coinsurance per prescription [Tier 1]] [[50 -100]% Coinsurance per prescription [Tier 2]] [[50 -100]% Coinsurance per prescription [Tier 3]] [[50 -100]% Coinsurance per prescription [Tier 4]] ~~[in addition to the Policy Deductible]~~ [plus any Ancillary Charge] [up to a 90-day supply]~~]~~ [not subject to Deductible]] [Out-of-Network Pharmacy: [$[50 – 1,000] Prescription Drug Deductible (per Policy Year) ~~[~~does not apply to Policy Deductible~~]~~] [$[0 - 450] Copay per prescription [generic drug]] [$[0 – 450] Copay per prescription brand-name drug] [[50-100]% of] [Usual and Customary Charges [generic drug]] [[50-100]% of] [Usual and Customary Charges brand-name drug] ~~[in addition to the Policy Deductible]~~ [up to a [30 - 31]-day supply per prescription] [after Deductible][not subject to Deductible]] [No Benefits outside of UnitedHealthcare Pharmacy]]

Other	
Ambulance Services	[$[25 – 1000] Copay [per trip] [per day] [ground] [air]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Durable Medical Equipment	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Consultant Physician Fees	[$[5 – 100] Copay per [outpatient] visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]

Other	
Dental Treatment [Benefits paid on Injury to Sound, Natural Teeth and treatment of cleft lip and cleft palate only.]	[$[5 – 75] Copay [per tooth] [per visit]] ~~-~~[[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] [Paid as any other Injury or Sickness] [No Benefits]~~]~~
[Dental Treatment Benefits paid for removal of impacted wisdom teeth only.	[$[5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [$[50 – 1,500] maximum [per procedure] [per tooth]] [after Deductible][not subject to Deductible]]
Mental Illness Treatment See Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]~~Paid as any other Sickness~~
Substance Use Disorder Treatment See Benefits for Mental Illness and Substance Use Disorder	**Inpatient:** [$[100 – 2,000] Copay [per day] [per Hospital Confinement]] [[50 – 100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **Outpatient office visits:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible] **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** [$[5 – 100] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]~~Paid as any other Sickness~~
Maternity See Benefits for Postpartum Care	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness
[Elective Abortion	[$[5 – 100] Copay [per procedure] [per visit]] [[50-100]% of] [Usual and Customary Charges] ~~[Paid as any other Sickness]~~ [$[100 – 1,000] maximum [per Policy Year]] [after Deductible][not subject to Deductible] [Paid as any other Sickness] [No Benefits]]
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied to Preventive Care Services. Please visit [https://www.healthcare.gov/preventive-care-benefits/] for a complete list of services provided for specific age and risk groups.	100% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness

Other	
[High Cost Procedures	[$[5 – 500] Copay [per procedure] [per service] [per visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]]
Home Health Care	[$[5 – 50] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [[90 – 200] visits maximum per Policy Year] [after Deductible][not subject to Deductible]
Hospice Care	[$[5 – 100] Copay [per day]] [[50-100]% of] [Usual and Customary Charges] -[[180 - 220] days maximum per Policy Year] [after Deductible][not subject to Deductible]
Inpatient Rehabilitation Facility	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [[90 – 180] days maximum per Policy Year [after Deductible][not subject to Deductible]
Skilled Nursing Facility	[$[50 – 1,000] Copay per day] [$[50 – 2,000] Copay per Inpatient admission] [[50-100]% of] [Usual and Customary Charges] [[60 – 180] days maximum per Policy Year [after Deductible][not subject to Deductible]
Urgent Care Center	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Hospital Outpatient Facility or Clinic	[$[5 – 150] Copay per visit] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Approved Clinical Trials See also Benefits for Clinical Trials	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits
Acupuncture in Lieu of Anesthesia	Paid as any other Sickness
Medical Foods	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Medical Supplies Benefits are limited to a 31 day supply per purchase,	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Ostomy Supplies	[$[5 – 500] Copay [per service or visit]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
Wigs	[$[5 – 500] Copay [per purchase]] [[50-100]% of] [Usual and Customary Charges] [after Deductible][not subject to Deductible]
[Insert any service excluded under the Policy (e.g. Acne)	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] [[10 – 100] [days][visits] maximum [per Policy Year] [for each Injury or Sickness]] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]

Other	
[Insert any non-essential service excluded under the Policy (e.g. hearing aids, obesity)	[$[5 – 2,000] Copay [per] [visit] [procedure] [service]] [[50-100]% of] [Usual and Customary Charges] ~~[Paid as any other Sickness]~~ [[10 – 100] [days] [visits] maximum] [per Policy Year][for each Injury or Sickness] [[$[50 – 10,000] maximum] [per Policy Year][for each Injury or Sickness]] [after Deductible][not subject to Deductible] [Paid as any other Sickness]]

District of Columbia
Form Filing List

Form #	Description
COL-17-DC (PY20) POL	**Blanket Student Injury and Sickness Policy Form**
COL-17-DC (PY20) CERT	Certificate of Coverage
COL-17-DC (PY20) SOB	Schedule of Benefits - Usual and Customary
COL-17-DC (PY20) SOB PPO	Schedule of Benefits - PPO
COL-17 (PY20) END RX	[UHCP] Prescription Drug Endorsement